DOCUMENT RESUME

ED 129 134 HE 008 187

TITLE	Workshop on Interdisciplinary Education--Kentucky January Prototype. Proceedings (University of Kentucky, April 15-17, 1975).
INSTITUTION	Kentucky Univ., Lexington. Coll. of Allied Health Professions.
SPONS AGENCY	Health Resources Administration (DHEW/PHS), Bethesda, Md. Div. of Associated Health Professions.
PUB DATE	17 Apr 75
CONTRACT	BHR-231-75-0204
NOTE	137p.; Not available in hard copy due to marginal reproducibility of original
EDRS PRICE	MF-$0.83 Plus Postage. HC Not Available from EDRS.
DESCRIPTORS	Bibliographies; Conference Reports; *Health Occupations Education; *Health Personnel; *Higher Education; *Interdisciplinary Approach; Program Evaluation; *Teamwork; Workshops
IDENTIFIERS	*Allied Health Professions; *Kentucky January Prototype

ABSTRACT

Participants were acquainted with the conceptual and operational details of interdisciplinary education in allied health as carried out in the Kentucky January Prototype. The program was developed in terms of the Health Team Model for the past four years, and has created a source of information on many facets of developing and programming interdisciplinary activities. Emphasis of the program was placed in two major generic areas: knowledge of the health-care environment and team experience. Representatives of 10 allied health units from across the country participated in the workshop. Attendee concerns relating to implementing a Kentucky January Prototype on their own campus centered on available money, scheduling problems, and in some instances ideology problems. Each participant was interested in working towards the implementation of such an effort on their own campus in spite of obstacles. Specific sections of the workshop report are devoted to program content, faculty development, student development, location coordinator development, evaluation methodology, bibliography of materials, and interdisciplinary references. (LBd)

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PROCEEDINGS

WORKSHOP ON INTERDISCIPLINARY EDUCATION -

KENTUCKY JANUARY PROTOTYPE

April 15 - 17, 1975
University of Kentucky
Carnahan Conference Center
Lexington, Kentucky

Conference Sponsor:

College of Allied Health Professions
University of Kentucky

Supported by:

Division of Associated Health Manpower
Bureau of Health Resources
Contract #231-75-0204

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INTERDISCIPLINARY EDUCATION - KENTUCKY JANUARY PROTOTYPE

I. Introduction

Interdisciplinary education as a concept has become a buzz word of health science educators. With much discussion there has been little investigation of the various and distinctive formats of interdisciplinary activity that have evolved. At the College of Allied Health Professions, University of Kentucky, there has evolved in conceptual terms a matrix of Generic Models of Interdisciplinary Health Science Programs (Table 1.). From this matrix the major emphasis of the College has focused on the "Health Team Model."

The Kentucky January Program, which has been developed in terms of the "Health Team Model" for the past four years, has created a source of information on many facets of developing and programming interdisciplinary activities. In an effort to maximize the knowledge available an invitational workshop was planned to disseminate relevant information and details pertaining to the development and implementation of the Kentucky January prototype on other campuses.

Representatives of ten Allied Health units from across the country were invited to participate in the workshop activities (Appendix 2).

The approach taken during the workshop was to outline how the Kentucky January prototype developed in terms of dealing with the Ten Basic Issues identified by the Program staff as common problems in interdisciplinary education

GENERIC MODELS OF INTERDISCIPLINARY HEALTH SCIENCE PROGRAMS*

	DISTINGUISHING CHARACTERISTICS	CONTENT	STUDENTS	FORMAT	COMMON TOPICS
I. TRADITIONAL MODEL	Primarily Interdisciplinary from a teaching standpoint	Multidisciplinary	Unidisciplinary	Lecture, discussion, etc.	1. Epidemiology 2. Legal Medicine
II. COMMON INTEREST MODEL	Topics related to common science requirements or "non-technical" aspects of health	Nondisciplinary (relative to health professions) Topical	Multidisciplinary	Lecture, discussion, seminar	1. Problems of Health Care Delivery 2. Financing Health Care 3. Moral and Ethical Problems 4. Anatomy
III. CASE PRESENTATION MODEL	Passive patient centered activity through relation of academic study to actual patient	Interesting Cases demonstrating principles of interdisciplinary comprehensive care	Uni- or Multidisciplinary	Clinical Case Conference	1. Disease Oriented 2. Social History Oriented 3. Rehabilitation Oriented
IV. HEALTH TEAM MODELS 1. RESEARCH TEAM		Study a particular problem through research methodology	Multidisciplinary	Independent or guided study through survey or other methods	1. Community Attitude Survey 2. "State of the Art" Studies
2. PATIENT CARE TEAM	Students from several disciplines share joint responsibility for some task which requires teamwork	Responsibility for provided comprehensive care jointly	Multidisciplinary	Clinical work with on or off campus with clinical conference a. Professional Orientation: Provided setting where proscribed disciplines learn to work together b. Patient Orientation: Provided setting where patient's needs proscribe the disciplines necessary for treatment	1. Role Definition 2. Interdisciplinary Communication 3. Integrated Patient Care 4. Non-Institutional Patient Care

* Adapted from a paper presented by Richard B. Fox, Medical Student, University of Minnesota, at the ASAHP Training Institute, August 1973, Minneapolis, Minnesota.

(Appendix 6). The conference proceedings are based on the logical progression of elements of the Kentucky January effort.

II. Program Concept Development

A. Goals

The initial goal of the Kentucky January effort was simply to develop an educational experience for students in Allied Health and other health science areas whereby they might be introduced to basic concepts of "teamwork". That original goal was then expanded into four goals:

1. An interdisciplinary learning experience which makes them aware of the total Health Care Environment and the role potential of their part-profession within that environment;
2. A shared experience which enhances their knowledge of the capabilities of other members of the Health Care Team;
3. An opportunity to experience activities and situations outside their discipline relative to health care; and
4. An experience which reinforces the community responsibility of the future health care professional.

Emphasis has been placed in two major generic areas: Knowledge of the Health Care Environment and team experience. While the goals themselves may appear simplistic in concept, they were complicated by the decision that they might best be reached by conducting the program off campus in "real" community settings.

B. Administrative Considerations

1. Organization

Philosophical decisions to involve students outside the College of Allied Health Professions, as well as to conduct the program off-campus forced several administrative decisions relative to program organization. In its original design Kentucky January was established as a unit within the Department of Community Health. This arrangement proved dysfunctional for two reasons:

1. status of program - as an internal unit of a department the program was placed in a difficult communicative position in relationship to dealing with departmental chairmen, deans, and campus personnel,
2. budget - with a distinct budget from the department, there are pressures to "share" financial resources which might run counter to the best interests of the program.

In a restructuring of the administrative aspects of the program the program office was moved to become a unit of the Dean's office, thereby resolving the status and budget problems.

Externally the program was organized to incorporate direct involvement by on-campus faculty, local people, administration and students.

There were essentially four personal elements involved in the organization of the "Kentucky January" Team Experience:

1. PROJECT DIRECTOR - UNIVERSITY OF KENTUCKY
2. FACULTY SPONSOR - UNIVERSITY OF KENTUCKY
3. LOCATION COORDINATOR - LOCAL HOSPITAL EMPLOYEE
4. STUDENTS - UNIVERSITY OF KENTUCKY

The relationship between the four at all times must remain flexible and circular in terms of organization. To clarify the function of each, the following broad statements of responsibilities are offered:

1. Project Director - responsible to faculty sponsor and students for provision of access to the necessary basic experiences that are consistent with the philosophy of the Health "Care" Environment; administrative assistance in provision of lodging and food while in the field; development of faculty sponsor leadership skills; work with location coordinator to insure adequate preparation of team prior to arrival in field and serve as a liaison between team and location coordinator.
2. Faculty Sponsor - responsible to students and location coordinator for assistance in smooth continuity of total experience; responsible to project director for assistance in evaluation of team experience; participates in planning of total experience in conjunction with students, location coordinator and project director.
3. Location Coordinator - responsible to project director in establishment of contacts for access to the necessary elements of the project philosophy; responsible to students and faculty sponsors for assistance in reaching all elements of the field experience; responsible to project director,

students, faculty sponsor for assessing local situation and advising what modifications should be made (if any) in the field experience program.

4. Students - responsible to project director for assistance in evaluation of project; responsible to faculty sponsor and location coordinator for conducting themselves in a professional manner; responsible to themselves to enter the field experience with an open and inquisitive mind realizing that this is an opportunity to expand their personal and professional horizons.

In essence there were several things to be accomplished with this structure:

1. academically - a student-faculty ratio of 6 to 1 was established for the field experience,
2. locally - each community was to have direct input into the program,
3. administrative - each faculty was provided individual back-up support for teaching and administrative details.

2. Financial

The original developmental support of the program was provided through a Special Project grant from the Division of Allied Health Manpower (Associated Health Manpower). This funding provided travel, faculty support, consultant support and developmental staff.

Utilizing state dollars, travel, housing and food support was provided to each student participating in the program. For the 1974-75 Kentucky January Program a cost of $140.00 per student for logistical support was incurred ($111.00 food and lodging, $29.00 transportation). Broken down into total units the Kentucky

January costs were $367.00 per student or $123.00 per credit hour generated. These costs include administration, supplies, consultants, travel, etc.

3. Communications

Any effort which attempts to cross departmental and/or college lines is bound to incur communications problems because the students and faculty were essentially a part of other established administrative units. The program staff developed a complex network basically set around verbal transmission of information by meetings and memorandum. Meetings with faculty and department heads continue throughout the year regarding the program efforts. There has been established a completely open communication system to keep all people informed of events related to the program. Other colleges were also approached and asked to name a liaison person for meeting attendance.

Externally location coordinators and hospital administrators are kept informed of program events through correspondence and meetings.

The importance of communications has been to allow as much input into the program as possible as well as to provide as much complete information as possible about changes and plans.

4. Program Timing

The timing of Kentucky January is a constantly raised question. January was selected as the time for the field experience for two simplistic reasons:

a. It was easier to insert in the curriculum in the middle of the school year as it related to continuity, and

b. by placing it in the middle of the year it was less of a problem for students regarding summer work plans.

The three week period of time for the program has been evaluated as probably about as much as students/faculty can tolerate physically due to the intensity of the experience. Students are informed of the program in their letter of acceptance to the College, thus being made aware of their off-campus obligation.

5. Public Relations

Public relations is an integral part of the total Kentucky January effort. Because the program is conducted in local communities their good will is essential to success. Internal public relations among College of Allied Health Departments as well as other University colleges is essential.

In the community photos of the team are mailed to local newspapers before their arrival. After the program letters of thank you to the community are then sent to the local newspaper.

Faculty and local participants in the program are then given membership certificates in the Kentucky January Society with additional letters of commendation for faculty to be placed in their file.

Participating clinical agencies are given official certificates designating them as clinical affiliates of the College of Allied Health Professions.

Each element contributing to the program both on and off campus is officially recognized in some way for their contribution to the program. While this is a time consuming part of the program it has a great reward.

6. Academic Considerations

The insertion of Kentucky January into a part of the University calendar brings about some administrative problems relative to late registration, fee payment, campus meals and housing, and missed coursework. Generally the program staff has anticipated these problems and resolved them with the various University office involved.

Kentucky January is listed as a course and carries three hours credit on a pass-fail basis.

C. Field Logistics

1. Living Arrangements

One of the early concepts of the administration of Kentucky January was to remove from the students and faculty as much of the logistical burden as possible. The program staff, through arrangements with local hospitals, provides all of the housing for students and faculty in dormitories, motels, hotels and private residencies. Each housing unit then bills the program directly. The students therefore do not need to pay out of pocket for housing. Food is handled by signing agreements with hospitals who in turn provide all meals to the teams. The average living cost per person in the field for 1974-75 was $111.00 per week.

2. Transportation

Each Kentucky January team is provided at least one car for transportation of the team. Students are allowed to drive personal cars, but are not reimbursed. Clinical teams are allowed three cars per team which are reimbursed. The 1974-75 cost per person for transportation was $29.00 for the three weeks.

The total program logistical cost per person for 1974-75 was $140.00 for the three weeks.

III. Program Content

A. Observational Teams

1. Converting Theory to Practice

The concept exemplified by "Kentucky January" was approved unanimously by the faculty of the College during its 1971 Fall Retreat. The faculty recognized that in attempting to educate competent and well qualified health professionals in a limited time period, the educational process often slighted the larger aspects of health care delivery and the inter-disciplinary instruction necessary for students to provide high quality health services. Kentucky January was to be the first step in the College's efforts to overcome this educational imbalance.

In developing the team experience for students, the Kentucky January design seeks to provide students with a problem oriented concept of "team," as opposed to a discipline oriented one. The team is lead by and composed of those disciplines which would best bear on a specific problem. Its leadership would differ as the problem differed and its membership would vary dependent upon the need. Under this concept "team" is a thought process whereby any one professional, by increasing his knowledge of the roles and capabilities of other professions, can call upon others more rationally.

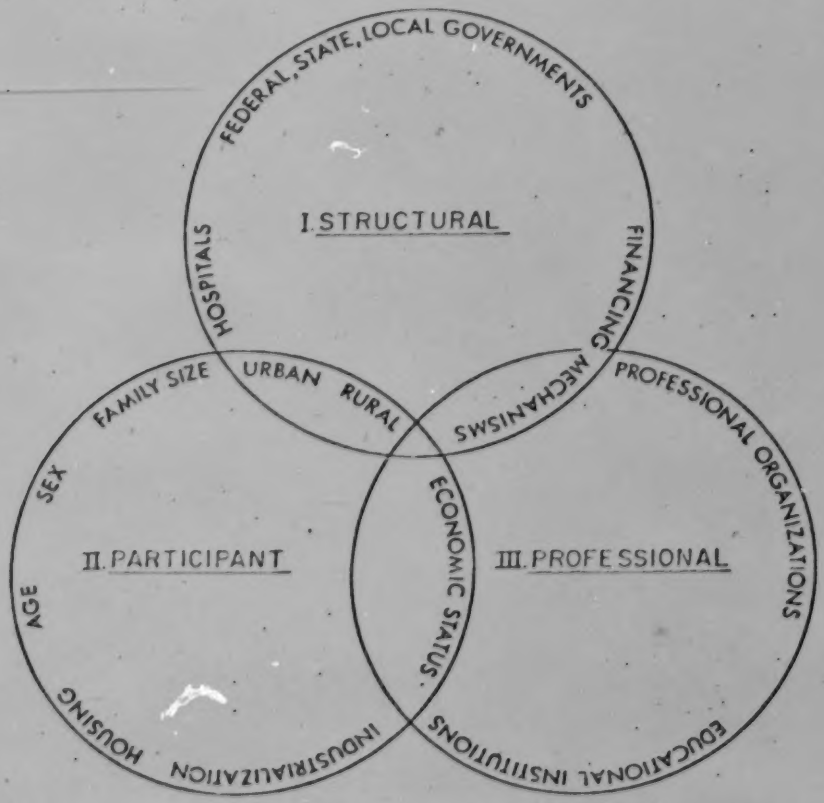
The team concept described above would be implemented by sending multidisciplinary groups of students to sites across the state and by giving them a common task -- observation

and analysis of each community's health delivery system. While in the field students would be given the additional task of exploring each other's professions in action in a community setting, and thinking through the relationships (and potential relationships) of their professional activities in relation to the total health care environment.

The field experience was structured on the basis of three models depicting the total scope of health care delivery -- "The Health Care Environment," " Factors Affecting How People Use Health Services," and "The Health Care Delivery System." The use of these three models brought about the structural division of the Program.

a. The Health Care Environment

This model was used to depict the total concept of a health system by illustrating the interaction of three sub-environments: structural, participant and professional.



The structural environment represents the forces of institutions designed to provide direct services to users. The dynamics of this environment are depicted in the Health Care Delivery System Model. The participant environment represents the users of services; their attitudes toward the system, the level of participation in decision-making, and characteristics of their use of the system. The third model, "Factors Affecting How People Use Health Services," depicts those characteristics of use. The professional environment represents the forces of educational institutions, professional organizations, and professional values and ethics.

The interaction of these three sub-environments - their relative power and influence, determine the nature and process of health services delivery in a given community.

b. Factors Affecting How People Use Health Services[1]

This model was used to represent significant factors related to the participant environment. Specific factors related to community use of services were broken down into Predisposing Variables, Enabling Variables and Perception of Need. Predisposing Variables, or the propensity to use services, were broken down into demographic, and socio-economic characteristics. Enabling variables, or the ability to secure services, included both personal resources and community resources. Perception of Need related to thresholds

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[1] A Behavioral Model of Familes: Use of Health Services. Ronald Andersen, Ph.D., Center for Health Administration Studies, Research Series 25, Graduate School of Business, The University of Chicago, 1968.

of pain and symptoms which needed to be met before use would occur.

c. Health Care Delivery System[2]

This model was used to demonstrate more fully the dynamics of the structural environment. Included in the model are the factors of Resources and Organization which mold the system into form. Also included are the levels of care provided in the community, ranging from quality of life services to primary, secondary, tertiary, and long term care.

Kentucky January was programmed to demonstrate experientially to students all of these models. The total experience is divided into three distinct episodes lasting approximately one week each.

a. Community Orientation - Students spend this period of time with local human service agencies, elected officials, and other community agencies learning about the structure of the community. The purpose here was to familiarize the student with all of the elements of community influence that affect the health care delivery system and to give insights into predisposing and enabling factors affecting how people use health services.

b. Acute Care Rotation - Students spend this next period of time rotating through and participating

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[2] Modified from Medical Care Use in Sweden and the United States - A Comparative Analysis of Systems and Behavior. Ronald Andersen, Ph.D., Bjorn Smelby, Med. Lic., Odin W. Andersen, Ph.D., Center for Health Administration Studies, Research Series 27, Graduate School of Business, The University of Chicago, 1970.

in all facets of hospital operation. Students were not to perform specific professional tasks, but could be called upon for helping tasks to give them some feel for the functions performed by the department. The purpose was to introduce students to the full impact of the secondary care setting and to give students insights into the resources and organizational dynamics involved.

c. Community Based Services - Students rotate through public health, home health agencies, nursing homes, physician offices, mental health clinics, and other community based health services. These rotations are programmed for various lengths of time to give the students as broad a view as possible of the health care delivery organization patterns in the community. This week was designed to complete the Health Care Delivery Systems model and to provide further insights into factors affecting use of the system.

The concepts of teamwork were to be demonstrated to students by observing teams in action, but even more so through the normal interaction among the interdisciplinary health professional students. Much of this interaction took place during nightly team meetings where the days activies were recapped and where plans for the next day were formulated. Frequently, members of the community joined the students and participated in the discussions.

2. Program Elements/Site Selection

In order to provide students the environment in which to observe and participate in the full scope of health services delivery, consideration needed to be given to the local settings in which the experience could occur. Each community, to be eligible for a Kentucky January team, had to provide at least six basic experiences for the students: 1. An acute care hospital with emergency room, 2. a health department, 3. a home health agency, 4. a nursing home, 5. a physician's office or clinic, and 6. an industrial tour.

Though these experiences provided the basis of the field program, location coordinators were encouraged to expand the number and types of settings to be visited. During the community orientation teams, in addition to industrial tours, visited with local officials, attended meetings of the city council and fiscal courts, viewed the juvenile and criminal court systems, rotated through social service departments, and were given overviews of the operations of the Area Development District and Comprehensive Health Planning Agencies. During the health services rotations students saw comprehensive care centers, psychiatric and respiratory disease hospitals, rehabilitation centers, health maintenance organizations, and neighborhood health centers.

In order to effect the University's liability insurance, each health service agency which accepts student rotations signs a Clinical Affiliation Agreement. The agreement

formalizes the roles and responsibilities of all parties concerned. Seventy-two such contracts were signed during the 1975 Program:

General Service Hospitals	28
Nursing Homes	13
Health Departments	13
Clinics	5
Home Health Agencies	5
Mental Health Centers	3
Other Hospitals	2
Neighborhood Health Centers	1
Private Practitioners	1
Social Service Agencies	1
TOTAL	72

Those institutions signing affiliation agreements were made formal Clinical Affiliates of the College and were awarded certificates attesting to that fact.

5. Resource People

Many other agencies and local people participated in the field experience. Each team was asked to keep a record of those persons making significant contributions to the learning experience. Over one hundred-fifty names were submitted to the program office. In addition to administrators of participating institutions, high on the lists were local elected officials and representatives of the Chambers of

Commerce. Lists for each site are provided to future teams for their use and a perpetual update of the list is encouraged.

4. Scheduling

Primary responsibility for planning the day to day schedule of student activities lies with the Location Coordinator. However, responsibility for planning the content of the schedule rests with all of the participants in the Program. Program Staff play an important role in providing aids to the Location Coordinator in contacting the necessary elements of the experience.

Each Coordinator is provided a "Team Site Checklist" which asks for names and addresses of those persons representing the 6 required elements of the field program. Additional space is provided to list those other resources to be utilized by the team. The information gathered here becomes the basis for the clinical affiliation agreements mentioned above. Each Coordinator is also provided with numerous aids to help explain the Program to others.

During the fall a meeting is held with all participants in the program for the purpose of planning specific field experiences. Here all of the resources available at the team site are reviewed and specific experiences are agreed upon. From this point the Location Coordinator makes the appropriate contacts and develops the schedule.

Several issues have been isolated regarding the scheduling process. The schedule should be flexible enough to absorb

the invariable foul-ups that occur. A mechanism should be built so that alternate experiences can be quickly set into motion should appointments be missed, timing miscalculated or other circumstances dictate. Such a mechanism relies highly on good communications among the location coordinator, faculty sponsor and students.

Time spent in any one department or agency is a constant issue. There is no general guide for this as departments and agencies from site to site vary so greatly. Time in a given location is generally a function of its size, complexity, departmental interest and student interest. In any case this is a judgmental factor that must be made on the local level.

Student evaluations generally point out that individual rotations are most highly beneficial where the student felt some level of participation. Though some rotations such as surgery and emergency room don't lend themselves to direct participation, helping tasks are usually available. In the past such helping tasks have included such activities as working on the food tray line in Dietary, "hand holding" of patients before surgery, admitting patients, home visits through the Home Health Agency, restaurant inspection through the Health Department, sweeping floors in Housekeeping. In each of these cases students reported a greater level of learning when participation was added to interviewing and observation activities.

Another common issue in scheduling is student interest. In many cases the student does not see the immediate relevance of a particular rotation. Here the role of the faculty sponsor comes to play as a motivator and interpretor of experiences. However, where student interest is low the time spent in that rotation should be modified accordingly.

5- Field Activities

The primary agencies which participated in Kentucky January were provided with a variety of educational programs and consultations. During the three years of the Project, faculty have presented over 45 programs for approximately 1,000 nurses, therapists and other health care professionals. Students have also given programs to approximately 800 persons. These programs generally involve explanations of health careers to high school students. A summary of educational and consulting services is included in Table II.

TABLE II

Continuing Education Programs and Consulting Activities

KENTUCKY JANUARY 1973-75

		1973	1974	1975	TOTAL
I.					
	A. Number of Faculty Educational Programs	11	12	22	45
	B. Number of Attendees	403	247	349	999
II.					
	A. Number of Student Educational Programs	0	7	8	15
	B. Number of Attendees	0	454	339	793
III.					
	A. Faculty Consulting Hours	72	45	18	135
	B. Student Consulting Hours	0	32	77	109
IV.	Educational Activities in Planning at Time of Report	4	5	3	12

In 1975 the observational teams faculty provided 22 educational sessions to 349 nurses, lab personnel, aids, orderlies, and clerks. A summary of faculty educational and consulting activities for the 1975 program is included in Table III.

Table III

FACULTY EDUCATIONAL AND CONSULTING SERVICES 1975

I. EDUCATIONAL ACTIVITIES

	TOPIC	PERSONNEL INVOLVED	NUMBER
1.	Nursing Care Planning (6 sessions)	Nurses	60
2.	Lymphocyte Morphology	Lab Personnel	10
3.	Specimen Collection	Nurses, aids, orderlies	40
4.	Managing Communications Disorders (2 sessions)	Nurses, aids	37
5.	Cardio-Pulmonary Recussitation	Nurses, aids	12
6.	Diabetes	Nurses, aids, clerks	24
7.	Burn Rehabilitation	Nurses	20
8.	Basics of Respiratory Therapy (2 sessions)	Nurses	29
9.	Infant Respiratory Therapy	Nurses	6
10.	Advanced Respiratory Therapy (2 sessions)	Nurses	36
11.	Stroke Rehabilitation	Nurses	75
		TOTAL	349 persons

II. CONSULTING ACTIVITIES

	TOPIC	HOURS
1.	Total Hip Replacement Therapy	1
2.	Physical Therapy Education	1
3.	Medical Lab Procedure	2
4.	Medical Lab Instrumentation	4
5.	Respiratory Therapy	10
	TOTAL	18 hours

Clinical teams proved quite productive in their provision of community services. A partial survey of team activities indicated that the students saw over 700 patients through home visits, screening services and other services. They provided Dental education programs to 400 students in seven elementary schools and to an undetermined number of diabetics in a program for diabetics in a high rise apartment building for the elderly. A summary of activities is included in Table IV.

TABLE IV

CLINICAL TEAMS PATIENT CARE AND SERVICE REPORT

KENTUCKY JANUARY 1975

Type of Activity	Number of Patients
Patient Contact	
1. Home Health Agency Visits	over 150
2. Family Planning Clinic (screening)	106
3. Health Department Clinic treatment and screening	78
4. Private Clinic Treatments	11
5. Nursing Home Treatments	2
6. Private Home Consultations	6
7. Vision and Dental Screening	285
8. Hypertension Screening	30
9. Hospital Staff Relief during flu epidemic .	undisclosed
10. Observations	24
11. Lead Screening in Day Care Centers	undisclosed
12. Sickle Cell Screening in day care centers	"
13. Diabetic screening in high rise for elderly	"
14. P. T. evaluations in high rise for elderly	"
15. Speech and Hearing screening in Day Care Centers	"
TOTAL	692
Patient Educational Services	
1. Dental Education Programs in 7 elementary schools	400
2. Diabetic Educational Program for elderly	undetermined
TOTAL	over 400

Other Services

1. Survey of 40 women regarding attitudes toward Family Planning clinic
2. UMWA Retirement Fund card holders survey (not completed)
3. "Resocialization Program" for elderly in rest home

B. Clinical Teams

While the bulk of the Kentucky January students participate in the observational program there is an emerging "clinical" concept of Kentucky January occuring. This clinical concept has occurred as a result of our evaluation process which indicated a need for a "hands on" experience for students.

1. Goals and Guidelines

The goals developed for that aspect of the program are to provide:

A. students the opportunity to explore the health care delivery system through provision of direct service to patients and/or families.

B. students experience in identifying factors affecting health care with a family and community focus and experience in defining treatment goals based on the patient's total situation.

C. students the opportunity to develop a flexible, user-oriented concept of health care team by allowing them to structure health care around the needs of the patient, altering the membership, function and duration of the team as indicated by the needs of its primary member, the patient.

D. students of the various health professions practice in functioning as a health profession with a unified purpose, the well-being of people, and with shared responsibility in planning for the achievement of goals established by the team.

E. students with strong professional role identification through observation of the unique contricutions from each team member to health planning and through the experience of relating their own special skills to the common purpose of the team.

F. students insight to the need to strive for more organized and less fragmented delivery of health care services.

To meet these goals students are assigned in teams to Home Health Agencies. The general Kentucky January prototype principles are essentially the same for the clinical teams: Three weeks in the field, on-campus teaching programs, six to seven students per team, and a full time faculty member assigned to each team. Even with these similarities it was necessary to develop a set of activity guidelines for clinical teams:

A. The student team will review patient records or referrals from the base agency, will select and evaluate patients, and they will have conferences to discuss their findings and to develop plans for service as indicated.
The specific contributions which each discipline can offer to the team should be studied in the perspective of the total health needs of the families. From the discussions, the group will develop an evaluation report on the health environment of each family, listing the major factors influencing this environment of each family, listing the major factors influencing this environment, listing changes or services which would improve health care for the family, and suggesting specific ways in which these changes or services could be provided. Differentiation must be made between goals actually related to health care and those related to attempts to impose the teams' own social values.

B. Evaluation of the total health environment and planning for health care must be done from sources in addition to family visits.
Some team members will contricute valuable information by investigating community resources or routine procedures in the community. All team members, regardless of discipline, will make some home visits, however.

C. Each student team member must have a professional resource person in the community (HHA preferred).
This person would provide professional guidance and supervision and carry on patient service after the student departs. The faculty sponsor should not be the professional resource person for his discipline, so that he will be able to deal equally with all team members and functions.

D. Direct service to patients will be initiated only if plans can be made for continuation of that service after the students depart.
All service provided will be under the supervision of the staff of the base agency. The student whose discipline would provide the service will be responsible for contacting the appropriate individual or agency in the community to plan follow-up and for reporting results to the team.

E. The faculty sponsor can and should offer valuable guidance in the team planning process of each phase of the clinical experience, but he should not impose his own ideas upon the team members.
Some structural guidance is necessitated by the time limitation and the students' lack of clinical experience. The objectives of the clinical team concept will best be met, however, through student-student and student-community-health care system interaction.

SUMMARY OF STUDENT ACTIVITIES

Each student member of the team will contact and be supervised by a professional resource person in the agency or community. He will carry out patient and/or family related activities in the following areas: evaluation, treatment, referral service, and health education. He will participate in a final critique of the team experience.

2. Faculty

The faculty for the clinical teams have been drawn from the predominantely clinically oriented disciplines available to the program staff, namely nursing and physical therapy. Each faculty person is nominated by their respective department and approved by the program staff.

3. Student Selection

Students for clinical teams are handled differently

from observation teams. Following the Spring informational meeting for the students going on the next year's program, students are allowed to volunteer for clinical teams. Their names are taken by the program staff who then request that the students volunteering for clinical teams be nominated by their respective faculties. The departmental faculty is requested to nominate the student based on clinical skill, flexibility, general cooperativeness, originality, and other such indefinable personal traits.

Upon nomination by their faculty the students selected then must make appointments with the clinical team faculty sponsors for a personal interview. Following this interview process the faculty sponsors for the clinical teams meet and determine which of the students they wish to have on their teams. Students which are not selected are placed back in the observational team pool for placement.

4. Fall Activities

The fall schedule for clinical teams is similar to that of observational teams with the exception of meeting intensity. There are three programmed staff-student meetings for orientation and teaching as well as faculty teaching sessions. However, the average clinical team faculty person spends nearly sixty-one hours in Kentucky January related activities as opposed to the observational faculty who spend thirty hours.

Clinical teams meet more during the Fall in small groups to discuss logistics and activity planning. They also make a field site visit to obtain a realistic picture of the region

and their clinical site.

5. Field Activities

During the field program the activities of the students are varied and literally dependent upon local resources. All teams essentially begin with home visits in conjunction with the home health staff. At the same time they are reviewing agency records in an effort to determine a patient potential for themselves. Some teams have opted for screening programs in local schools or day care centers in an effort to pick up their own patients. From these screening programs the students then make home visits. Students have centered their activities in geriatric centers, day care centers, homes, clinics, schools and literally any area which provided them entree'.

Student activities have included treatments, education, substituting for staff, doing studies and surveys, consulting with other professionals in the community, quality control studies and other such activities. It is literally impossible to completely delineate all of the student activities. They are guided in their activities by faculty and local consultants thus providing a quality control mechanism.

IV. Faculty Development

1. Faculty Selection

Faculty are perhaps the most critical element of the Kentucky January program. Their organizational and teaching efforts during the program from Fall through the evaluation in the Spring keep both students and program activity at a high level. Generally, each department with students participating in Kentucky January is required to furnish one faculty person for every six students going to the field. Faculty volunteer through their department and then are finally approved by the program staff.

Being a Faculty Sponsor for Kentucky January is a unique personal and teaching experience. Because faculty are in the field with students on a twenty-four hour basis, there is a great deal of personal contact between teacher and student outside of the traditional on-campus situation. This intensive contact is an important aspect of the program. In addition faculty must deal with the representatives of our clinical affiliates in the field.

Personal time commitment for Kentucky January entails the following components:

1. Program organized meetings - Fall semester
   10 meetings
2. Informal student meetings - 4 meetings
3. Off-campus trip to site - 1 day

During the Fall of 1974, Kentucky January faculty averaged 35 clock hours of time on Kentucky January preparation with a range of 5 - 100 hours. During the January field experience faculty reported an average of 183 hours time commitment.

The uniqueness of the faculty sponsor role as a teaching experience has led to the development of the following check list:

SKILLS FOR EFFECTIVE KENTUCKY JANUARY FACULTY SPONSORS

The following items describe behaviors that are associated with effective faculty sponsor activity. These items are presented as a stimulus for thought about the skills faculty sponsors may need in order to work effectively with their students.

Facilitating Learning of Students

1. Helping students reflect on and learn about their own style of learning and problem solving.

2. Helping students use their Kentucky January experience to better understand their own profession, interdisciplinary concepts, and the health care delivery system.

3. Helping students assess the objectives of their Kentucky January experiences for their own understanding of their values, future directions in career, and community experience.

Support for Experiential Learning and Problem-Solving

4. Encouraging students to be active participants in defining their own purposes for participating.

5. Helping student teams set specific, moderate-risk, learning, and problem-solving objectives.

7. Helping students interpret data generated by their own learning and problem-solving experiences.

8. Making information and other resources available to students that might help them in their learning and problem-solving.

9. Developing warm and trusting relationships with students.

Working with Agencies

10. Assisting location coordinators support learning objectives of the student.

Group Facilitator Skills

11. Helping students reflect on their concrete experience in group settings.

12. Facilitating group discussion rather than directing.

13. Encouraging students to be effective consultants with one another.

14. Developing own learning objectives while working with students.

15. Setting standards, measuring and evaluating student learning in Kentucky January experiences.

Generally faculty are also faced with issues relating to time commitment and teaching loads while based on the campus. These are resolved by various departments through relief time and or other means.

2. Faculty Teaching Programs

The role of faculty sponsor in an off-campus, non-discipline oriented program is definitely a new experience for most faculty. Recognizing this the program staff has designed a teaching materials manual which includes strategies, objectives, and teaching tools. Coupled with this manual each Fall the program staff conducts a seven hour training program for faculty highlighting the various issues related to this type of teaching program.

For the Fall of 1975, the teaching program will include topics such as general orientation to Kentucky January, roles and expectations of faculty sponsors, group dynamics and problem solving, health care delivery systems - what to look for, program scheduling and models and teaching teams - tools and techniques.

Faculty receive their materials manuals during the first teaching session. Each faculty session is programed to fit approximately at the appropriate time in the team's growth in order that the faculty is at least one page ahead of the students.

3. Faculty Sponsor Evaluation

The faculty sponsor concept is essentially evaluated directly by three elements of the program - students, faculty sponsors and location coordinators. There has been a constant eighty percent positive response by students to the faculty

sponsor concept. Faculty evaluation has been one hundred percent positive relative to the faculty sponsor concept and location coordinator response is also positive.

Students and faculty continually identify "personality" traits as more necessary to faculty sponsor success than knowledge relative to health care. Based on these evaluations we have also used selected graduate students as faculty sponsors with success.

The concept of the faculty sponsor has proven to be one of the most effective aspects of the Kentucky January effort.

V. Student Development

1. Student Selection

In order to be eligible for the Kentucky January experience, participating students must be in a professional curriculum related to health services delivery and should be in the last semester of their on-campus training. These "common denominators" permit a mix of students not commonly encountered in more traditional educational settings. Student participants have originated from programs offering associate degrees through doctoral degrees without any negative results. Arguments citing dissonance in maturity, clinical ability or degree of interest have been unfounded based on evaluative reports.

The selection process begins in April of each year. At this time prospective students are invited to an information meeting. Activities from prior years are emphasized in the meeting as well as the time committment and expectations of students. Participants from previous years are also invited to speak to the students to detail personal experiences and to give "advice" to enhance the experience. Application forms are then distributed to interested students.

The application form provides information necessary for two purposes. First, the staff can form an early estimate of student volume for program planning. Second, the information obtained is an indispensible aid in terms of team composition. Specific data sought include name, discipline, grade level, marital status, previous experiences, availability of a car for use during the program, site preference (urban or rural) and team preference (clinical or observational).

During the fall semester additional meetings are conducted with students from specific programs outside the province of the College of Allied Health Professions. None of these meetings are meant to actively recruit participants. The information meetings are held only at the invitation of a particular program. However, additional applications are accepted during these meetings.

2. Team Composition

Student placement on specific teams is essentially random. There are some general guidelines, however, which are necessary to accomplish both program and logistical objectives. To the extent possible, no two disciplines will be duplicated on a given team. To do so would violate a central tenet of the team philosophy; to expand awareness of the knowledge and skill possessed by other professions. For this reason, duplications only occur when the number of students of a given discipline outnumber the available sites.

Students will not be sent to a site in the vicinity of their home town. The Program purposely fosters an atmosphere of interdependency of students on each other by sending them to sites where they have had no previous contact. The mutual insecurity helps draw the team together by its natural common denominators of interest in health sciences and University identification.

Certain logistical considerations must also be taken into account. To the extent possible, the staff attempts to honor student requests for Urban or Rural locations. Transportation becomes a critical factor in the field, so each team is assigned

at least two students who own cars. Married students are generally assigned sites closer to Lexington to minimize the emotional impact of a three week separation.

3. Student Participation

In the short three year history of Kentucky January to 1975, some 390 students and 73 faculty have participated in the program in 30 sites across the Commonwealth. In 1976, approximately 200 students and 25 faculty will be added to the roles. These students and faculty represent 20 academic departments, 11 colleges, 18 disciplines and 4 Universities. Table V details the level of participation by department.

TABLE V
UNIVERSITY OF KENTUCKY
COLLEGE OF ALLIED HEALTH PROFESSIONS
KENTUCKY JANUARY

Student and Faculty Participation: A Three Year Summary

DEPARTMENT	1973		1974		1975		Total	
	Studs.	Fac.	Studs.	Fac.	Studs.	Fac.	Studs.	Fac.
Community Health, BHS	10	(1)	19	(5)	23	(4)	52	(10)
Physical Therapy, BHS	16	(2)	17	(3)	20	(7)	53	(12)
Medical Technology, BHS	8	(1)	32	(3)	26	(4)	66	(8)
Dental Hygiene, BHS	4	(1)	16	(2)	16	(2)	36	(5)
Clinical Pastoral Counseling	1	(1)	2	(1)	3	(1)	6	(3)
Center for Learning Resources, BHS	3	(3)	9	(5)	2	(2)	14	(10)
Clinical Associate, Certificate	0		0		1	(1)	1	(1)
Nursing, BSN	0		18	(3)	13	(4)	31	(7)
Respiratory Therapy, AA	10	(2)	6	(2)	0		16	(4)
Nursing, AA	15	(2)	4	(2)	6	(1)	25	(5)
Radiologic Technology, AA	3		12	(1)	16	(1)	31	(2)
Social Professions, BS/MS	0		6	(1)	14	(2)	20	(3)
Speech and Hearing, BS/MS	10	(1)	10	(1)	10	(1)	30	(2)
Dentistry	0		1		0		1	
Pharmacy	0		4		0		4	
U.M.S.C.-Physical Therapy, BS	0		0		2		2	
Nuclear Medicine Technology, AA	0		0		2		2	
TOTALS	80	(14)	156	(29)	154	(30)	390	(73)

4. Teaching Program

The brunt of the teaching program for students is the responsibility of the individual faculty sponsor for the team. Faculty are expected to meet with their teams at least 4 times during the Fall semester to review the concepts of "team" and "health care environment" and to do preliminary research and planning for their particular team site. The major staff role in the student teaching program is to develop the materials for these meetings and to train faculty for their new role.

In order to assure that everyone starts the program with a common knowledge base three general student meetings are called during the fall semester. The first meeting is held in September. The purpose of the meeting is to form the teams, review the purposes, philosophy, objectives and logistics of the Program and to more extensively outline student responsibilities. The second meeting, held in October, outlines what students can expect to encounter in the field. In addition a video tape of past student evaluations is shown. The third meeting reviews the academic aspects of the experience. Held in November, this meeting discusses the field models related to the health care environment, the philosophy of team and how the activities in the field relate to the academic field models.

In addition to the three Program meetings, each student is given a Study Guide and Resource Manual which details all aspects of the Program. Included in the Manual are such topics as Program Organization and Activities, Logistics, Student Obligations, Social Survival, Resources and Expectations, and explanations of the Field Models and philosophy of Teamwork.

5. Issues Related to Students

Invariably in an interdisciplinary program of this size and nature, issues and problems will arise regarding student commitment and participation.

All baccalauriate students in the College of Allied Health Professions at U.K. are required to participate in Kentucky January. The College of Allied Health, however, only accounts for approximately 55% of the student population in the Program. The other 45% of students volunteer for the experience. The issue arises as to whether the experience should be voluntary or mandatory.

The attitudes of mandatory students toward the program are uniformly lower when compared to voluntary students. An analysis of grade scores which reflected level of preparation, field activities and program completion showed mandatory students to score approximately one grade level lower than voluntary students. When programs were analyzed individually, however, another trend emerges. Students from those mandatory programs whose on campus faculty strongly endorsed the concept scored on a level with voluntary students. The conclusion to be drawn here is that motivation is not strictly a function of volunteerism, but the level of faculty support.

Related to the issue of whether or not a program of this nature should be voluntary or mandatory is the issue of student drop-outs. Though volunteers are generally better motivated for the experience, they are less reliable in terms of planning for the teams. Of 177 students initially placed on

Kentucky January teams in 1975, 31 dropped out, a rate of 14%. There are several implications of this problem:

1. Team Effectiveness:
   Small group dynamics studies have shown the most effective groups to consist of 6 - 12 participants. The Kentucky January standard limits groups to six or seven participants. This year 13 teams were sent out with five student participants, two teams with only four student participants. This seriously hampers efforts toward the "team" goals of Kentucky January.

2. Team Preparation:
   Related to team effectiveness is the problem of disruption of team composition due to the imbalances caused by drop outs. The constant re-shuffling of students to balance team composition leads to futility in attempts for continuity in preparation. This problem affected 21 of 28 teams.

3. Cost:
   Placement of a team in the field this year cost an approximate average of $900 just for food, lodging and transportation. The net loss of 23 students is equivalent to four teams, costing the Program $3,600.

In anticipation of drop-outs for the 1976 Program, the number of sites were cut down. In addition students were told more emphatically in informational meetings of the time requirements and expectations. Students who were unsure of their ability to participate were asked not to apply. Ironically the two measures have proved to be too strong. The program experienced a general oversubscription and few drop-outs. Eight and nine students are being placed on a team rather than the six or seven previously assigned.

Since the Program crosses college and university lines the problem of conflicting academic schedules is constantly present. The Spring semester for voluntary students usually begins seven school days before students return from the field.

As a result, a student who is affected by a schedule conflict must gain permission from the faculty for on-campus courses before he may participate. Such permission has generally been granted with few problems.

VI. Location Coordinator Development

One of the keys to the success of the Kentucky January effort is the utilization of local individuals who serve as location coordinators.

The Location Coordinator provides the planning and liaison function for the Kentucky January team. Working in conjunction with College faculty, this person schedules and works with students in moving them through the Kentucky January process in the local area. They provide a teaching function by relating each community to the students on the team. At the same time they relate the objectives of Kentucky January to local people who are working with the students.

1. Selection Process

In each Kentucky January site a hospital is selected as the base institution. From the base institution a request is made for an individual to serve as the location coordinator. We have generally requested that the location coordinators be individuals who have a community orientation. To date we have had directors of inservice education, directors of nursing service, public relations directors, assistant administrators, administrators, controllers, and some people without specific titles serve as location coordinators. We have normally requested that hospital administrators not serve in this capacity because of the time commitments.

Each location coordinator is given a voluntary faculty appointment in the College for one year in the Department of Allied Health Education and Research.

2. Location Coordinators Activities

The activities of the location coordinators are varied. Surveys of their activities show that they spend on the average of fourty-three clock hours in Fall preparation for the students. These activities include meeting with hospital personnel, contacting community agencies, meetings with program staff, meetings with faculty and students, and miscellaneous activities.

During the program the location coordinator devotes approximately thirty-six hours to the program in contact with the faculty and students. The total time commitment for these people is thus approximately seventy-nine hours.

3. Preparation and Evaluation

During the Fall the location coordinators are brought to Lexington for a two day meeting. The purposes of the meeting are program planning,education, and social. During the meeting the program staff briefs the location coordinators on things related to the program such as objectives, new devolopments, student concerns, faculty inputs and capabilities as well as logistical concerns. The location coordinators are then brought together with faculty for a direct planning session for scheduling student rotations and activities. They are also given time to meet with the student team.

In the spring the location coordinators and faculty are brought together again for a program evaluation session during which issues and recommendations are discussed.

VII. Evaluation Methodology + Results

1. Methodology

We are constantly attempting to obtain some reliable evaluation of our Kentucky January efforts on both the objective and subjective levels. The newness of this type of program precludes any precedent in evaluation tools or format. However, we have received valuable assistance from the Center for Learning Resources of the University of Kentucky College of Allied Health Professions in our continuing efforts. The evaluation procedure for Kentucky January will include the following instruments in 1975:

NAME	ADMINISTRATION	METHODOLOGY	PURPOSE
Team Effectiveness Scale	Pre Test Mid Term Post Test	Subjective/ Ranking	To measure the student and faculty perception of their team effectiveness over the period of the field program. The eight parameters measured are: Goals, Participation, Feelings, Diagnosis of Group Problems, Leadership, Trust, Creativity & Growth.
Snodgrass Health Professional Attitude Survey	Pre/Post Test	Subjective/ Ranking	To measure student and faculty affinity (and any changes) toward other health professions based on 9 standard personality traits.
Health Environment Delivery System	Pre/Post Test	Objective/ Multiple Choice	To measure the students and faculty knowledge (and change) of the health care system.
Kentucky January Student Questionnaire	Post Test	Subjective/ Open-ended	To gain knowledge of student feelings and suggested changes regarding Kentucky January

NAME	ADMINISTRATION	METHODOLOGY	PURPOSE
Kentucky January Faculty Questionnaire	Post Test	Subjective/ Open-ended	To gain knowledge of faculty feelings and suggested changes regarding Kentucky January.
Kentucky January Location Coordinator Questionnaire	Post Test	Subjective/ Open-ended	To gain knowledge of location coordinators' feelings, activities and suggestions for change regarding Kentucky January.
Regional Reports	Post Test	Subjective/ On A-V Tape (one student selected per team	To preserve student feelings, activities and suggested changes for use in explaining the program to others and as an orientation tool for next year.
Team Reports	Post Test	Subjective/ Essay	To relate local environment to field models provided in student resource manual. Used to help orient next year's team and-gives subjective measure of lacks in student preparation.
Faculty Reports	Post Test	Subjective/ Essay (Optional)	To increase knowledge of the process of team growth.

ADMINISTRATION SCHEDULE FOR THE EVALUATION INSTRUMENTS IS AS FOLLOWS:

DATE	INSTRUMENTS	SUBJECTS
November 22, 1974	Group Effectiveness Scale (Pre-Test)	Observational Teams
December 11, 1974	Group Effectiveness Scale (Pre-Test)	Clinical Teams
January 5, 1975	Snodgrass Health Environment (Pre-Test)	Clinical Teams
January 6, 1975	Snodgrass Health Environment (Pre-Test)	Observational Teams
January 15, 1975	Group Effectiveness (Mid-Term Test)	All Teams (Optional)
January 27, 1975	Group Effectiveness Snodgrass Health Environment (Post Tests) Student Questionnaire Faculty Questionnaire	All Teams
January 27-28, 1975	Regional Reports	All Teams
February 7, 1975	Team Reports	All Teams
March 14, 1975	Location Coordinator Questionnaire	All Teams
Anytime during Spring Semester	Faculty Reports	Selected Faculty (Optional)

2. Quantitative Results.

The results of the quantitative pre and post-tests were computerized and measured on several parameters. Table VI. summarizes the population parameters in the quantitative analysis.

We have found, through our quantitative tests, that students and faculty did in fact meet the Program objectives. Students reported statistically significant growth in team effectiveness ($P. < .001$, two tails). Faculty also reported statistically significant growth both in team effectiveness ($P. < .001$, two tails) and in knowledge of the health environment ($P. < .05$, two tails).

Though the Program experienced success when all students are considered, varying results occur when the data is broken down by discipline. Community Health Educators did not report statistically significant growth in the Team Effectiveness sub-sales of Goals, Participation, Feelings or Creativity. Dental Hygienists reported very little statistically significant growth in Team Effectiveness, the only significant growth recorded in the areas of Problems and Trust. Dental Hygienists were the only population parameter under study which did not report statistically significant growth in overall team effectiveness.

Three of the seven disciplines under study did not increase their knowledge of the health environment to a statistically significant level. This occurred in Community Health, Radiologic Technology, and in Speech and Hearing.

TABLE VI

Population variables and Parameters included in the Kentucky January Quantitative Analysis

VARIABLES	PARAMETERS
1. Type of Team	a. Clinical (N=26) b. Observational (N=119)
2. Student Attendance Status	a. Voluntary (N=74) b. Mandatory (N=71)
3. Team Setting	a. Urban (N-68) b. Rural (N=77)
4. Students by Discipline	a. Community Health (N=21) b. Physical Therapy (N=22) c. Medical Technology (N=26) d. Dental Hygiene (N=15) e. Nursing (N=18) f. Radiologic Technology (N=15) g. Speech and Hearing (N=10)
5. Total Student Population (N=145)	
6. Faculty (N=25)	a. Faculty (N=25)

Several trends developed on the Snodgrass scales. Faculty, whose experience was wider and attitudes well entrenched, increased their affinity toward other professions to a far lesser extent than did students. Significant increases in affinity were reported by faculty toward Physicians and Radiologic Technologists ($P.<.10$, two tails, for both professions). Students, on the other hand, significantly increased their affinity toward Medical Technologists ($P.<.001$, two tails), Radiologic Technologists ($P.<.001$, two tails), Respiratory Therapists ($P.<.10$, two tails), Social Workers $P.<.10$, two tails), Speech Pathologists and Audiologists ($P.<.10$, two tails), and towards Pharmacists ($P.<.01$, two tails). Students who had little experience with other professionals in their curricula, Medical Technologists and Speech and Hearing Students, increased their affinity toward more professions than did those with more interprofessional contact.

Three disciplines reported a statistically significant decrease in affinity toward some professions. Physical Therapy students felt a lower affinity toward Nursing ($P.<.02$, two tails), and toward their own profession ($P.<.05$, two tails). Medical Technology students felt a lower affinity toward Nursing ($P<.10$, two tails). Dental Hygiene students reported lower affinity toward physicians ($P<.02$, two tails).

Little can be said in way of explanation for this phenomenon. One possible explanation could be that the Physical Therapy, Medical Technology and Dental Hygiene students are returning to campus with a more realistic view

of the Professions in question. This contention is somewhat reinforced by the pre-test data which show that in three of the four cases of decreased affinity, pre-test scores toward those professions where higher than the scores from the total student population.

Two additional patterns emerged from the data. Dental Hygiene students reported very few significant changes in both Team Effectiveness and Snodgrass Scales. However, they did show significant improvement on the Health Care Environment/ Questionnaire ($P < .05$, two tailed). None of the Population groups under study indicated a statistically significant increase in affinity toward Community Health Educators. Though such patterns lead to speculative explanations, the available quantitative data give few clues as to the reasons behind them. Analysis of pre-test scores for Dental Hygiene students show consistently higher rankings for both Group Effectiveness and Snodgrass Scales than the total student population. Post-test scores indicate that the Dental Hygiene students are more in line with the total student population.

A summary of those population parameters experiencing significant differences in the pre and post test are included in Table VII. Those areas where a significant difference was found are reported by the level of significance on a two-tailed test. Those areas where no significant difference was found were left blank.

Analysis of the quantitative results between population parameters (eg: Clinical vs. Observational teams) produced no statistically significant results, however, several interesting points were raised.

1. Though observational teams experienced dramatic growth in group effectiveness compared to clinical teams over the three-week KJ span, clinical teams entered the field with a much higher sense of group effectiveness. This compares very favorably to faculty preparation time -- clinical faculty spent twice as much preparation time than observational faculty (60 and 30 hours respectively).

2. Observational teams experienced a greater increase in knowledge of the health system as measured by the Health Care Environment Questionnaire than did clinical teams.

3. Rural teams reported a greater level of growth in team effectiveness than urban teams, but experienced a lesser increase in knowledge of the health system.

4. Several faculty and location coordinators drew a positive relationship between experiences in the field and attitude changes toward professions listed on the Snodgrass Scale. This tends to reinforce one premise of Kentucky January, that attitudes (and blocks to communication and teamwork) are formed by direct experiences with individuals, then generalized to professions.

5. Weakness in the teams still exist in the general areas of preparation, goals, leadership and participation.

"Significance Levels for the differences within groups- by group and test parameter." (P.< _____)
(t test for significant differences for dependent samples. Two tails.) $t=(\sqrt{n})\frac{\bar{D}}{S_D}$

POPULATION GROUPS

TEST PARAMETERS	FACULTY	ALL STUDS	CH	PT	MT	DH	RN	RT	SH
GOALS	.01	.001		.01	.05		.05		.02
PARTICIPATION	.001	.001		.01	.01		.05	.10	.01
FEELINGS	.01	.001		.01	.01				.01
PROBLEMS	.001	.001	.10	.001	.001	.05	.10	.01	.01
LEADERSHIP	.10	.001	.02	.001	.01		.05	.05	.02
DECISIONS	.001	.001	.10	.01	.02		.01	.02	.01
TRUST	.001	.001	.05	.01	.001	.10	.02	.02	.01
CREATIVITY	.001	.001		.01	.02		.01	.02	.01
TOTAL	.001	.001	.10	.01	.02		.02	.02	.001
NURSE				.02	.10			.10	
PHYSICAL THERAPIST				.05	.02				.05
PHYSICIAN	.10					.02	.10		
MEDICAL TECHNOLOGISTS		.001	.10				.10		
COMMUNITY HEALTH EDUCATOR									
DENTAL HYGENIST			.05						.001
RADIOLOGIC TECHNOLOGIST	.10	.001	.05	.001	.01		.05	.10	.001
RESPIRATORY THERAPIST		.10			.10				.05
SOCIAL WORKER		.10			.10				.05
SPEECH AND HEARING		.01						.05	
PHARMACIST		.01	.02						.05
HEALTH CARE ENVIRONMENT QUESTIONNAIRE	.05	.001		.001	.001	.05	.02		
DEGREES OF FREEDOM	24	144	20	21	25	14	17	14	9

TEAM EFFECTIVENESS SCALE

SNODGRASS SCALES

3. Qualitative Results

Students, Faculty Sponsors and Location Coordinators were asked to respond to subjective questionnaires, designed to seek improvements in the Program design and administration. The questionnaires covered four major areas of the Program: Activities, Faculty Sponsor, Living Conditions and General Comments.

a. Program Activities:

The major student theme in the program evaluation continues to be the scheduling of activities. Many students (though less than in previous years) felt the length of time off campus should be reduced from three to two weeks. More often the comment emerged that too much time was spent in particular departments or agencies. Students often felt extremely frustrated interviewing and listening as opposed to participating in activities. The most often stated suggestion in this regard is to increase the level of student participation in all levels of activities planning as well as in the activities themselves.

Students also expressed a need for more time to prepare for and integrate their Kentucky January experience. The response to this year's orientation program was quite negative, citing its length and immediately perceived relevance to the upcoming program as its major detrements. Despite the expressed need for more participation, planning and integration, 80% of

the respondents felt prepared to go to the field. Sixty-six percent felt that the Study Guide and Resource Manual was helpful as a tool for preparation and integration. The reasons most often given for adequate preparation were: the resource manual, team meetings, team objectives were formulated, and an open mind.

Faculty responses centered primarily on co-ordination and planning of on-site activities and on student participation. Many faculty felt a need to better prepare themselves for the site--gathering community resource data, becoming better acquainted with on-site personnel and better organizing their team. With greater knowledge of the site, more student participation in planning the schedule could be incorporated.

Faculty also lamented the fact that students didn't seem to possess the technical skills to fully appreciate the experience they were receiving. More team meetings and better preparation could help alleviate the problem.

Location Coordinators again expressed a need for better student preparation and better scheduling of activities. Major suggestions centered around student site visits prior to the formal Program, better conceptual preparation, and more flexible scheduling.

b. Faculty Sponsor Concept

It appears once again that personal characteristics are the dominant factors in student evaluation of faculty. Seventy-five percent (75%) of the responses (124 of 165) were "Yes" to the question, "Did the presence of the faculty sponsor

help make the experience worthwhile?" However, this is a 5% drop from last year.

Totally negative response to a faculty sponsor occured in only one group. In three groups the concensus of student opinion was negative. In all of these situations the overwhelming explanation by the groups was that the sponsor was "too domineering", "assumed leadership" and "did not participate in team activities".

Faculty gave unanimous support to the concept of a faculty sponsor for Kentucky January teams. The issue has evolved not to the presence of a sponsor but to the amount of time a faculty person should give. No real concensus was reached. One faculty sponsor summed up the issue quite well by saying, "It works best when the concept of shared leadership is a reality. If leadership by students can begin before (Kentucky January), the faculty sponsor is less necessary in the experience itself."

Location Coordinators strongly endorse the concept. The general concensus here is that the presence of the faculty sponsor indicates a strong academic component to team activities and shows the community that the University has real concern for its students.

c. Living Conditions

One of the historical problems facing the Kentucky January Program has revolved around food, lodging and transportation for the teams. This year the responses were relatively positive. Eighty-four percent (84%) of the students and eighty-six percent (86%) of the faculty positively evaluated

the housing arrangements. Complaints centered on the cleanliness and crowded conditions in some motels. Arrangements for meals in local hospitals were more successful, 89% of the students and 82% of the faculty responded positively. The major complaint was the inconvenience of traveling to the hospital for meals while the team was out in the community. There were many complaints concerning transportation arrangements due primarily to the lack of funds to reimburse students for their mileage.

.Twenty-one percent of the students were willing to pay between $10.00-$15.00 for their own housing and forty-one percent were willing to pay $12.00-$15.00 for their own meals. This is comparable to the responses in the 1973-4 evaluation responses.

d. General Comments

Responses to the general questions are lengthy and very difficult to categorize. Despite the complaints concerning logistics, the general tone of the remarks indicates that both students and faculty greatly benefited from the experience. In response to the question--"Do you feel that you now have a better idea about what other health care professions are capable of doing for improvements in health care delivery?", ninety-four percent of the students responded "yes", an almost equal response to those in 1972-3 and 1973-4.

Faculty indicated that they too had a better understanding of other professions (77%). This is an increase of 7% over

last year and indicates an openness of faculty to treat Kentucky January as a learning as well as teaching experience.

While a number of specific comments will be made a available at a later date, the following are representative of the summary remarks.

STUDENT

"As a result of Kentucky January, I am better able to utilize the other disciplines in reaching quality patient care in hospital, community and politically. Our group was a rather unusual one in that our personalities were very compatible socially, but we worked well in the working situation and would have regardless of our social interaction. I found that we stimulated each other to learn and want to be involved in the development of health care programs outside of actual patient care within our disciplines. As a result, I feel very satisfied and important as a nurse and knowing how to relate to the other medical disciplines. This was a very stimulating valuable experience to get involved in health care delivery outside my profession. I saw the needs to improve quality of health care in rural area."

FACULTY

"Three busy weeks that brought six individuals together in a strange environment. The community responded with a hospitality, frankness, and interest that allowed the students to see the good and the "ugly" things that go into the mental and physical well being of the people within the community.

Above all, for three weeks, six individuals thought, laughed, learned and sometimes cried together."

"Overall, I was pleased with my experience. I feel I gained in learning how to interact with students. I now feel that I could better organize myself and my team, could better prepare my team for going out into the field, having done the experience. For me, this year was more of a personal experience - interpersonal relationships."

LOCATION COORDINATOR

"I feel Kentucky January is a very effective Program, producing measurable results for the students, faculty and all hospital personnel who are involved with the students. Our department heads, supervisors and employees enjoy their involvement with the students. Many look forward to the program each year."

VIII. Participant Reports

1. Faculty Panel

Four past Kentucky January Faculty Sponsors were invited to speak with the workshop attendees regarding their experiences in and views toward the Program. Two of the Faculty Sponsors represented clinical teams. Mr. John Wadsworth, coordinator of graduate studies in Physical Therapy, sponsored the team based at the Visiting Nurse Association of Louisville. Ms. Ruth Assell, Division director of Community Health Nursing, College of Nursing, sponsored the team based at Morgan County ARH, Home Health Agency. The remaining two faculty represented observational teams. Mr. Ken Martin, an assistant professor in the department of Medical Technology, sponsored the team based at Morehead St. Claire Medical Center. Ms. Susan Lipscomb, Assistant professor of Radiologic Technology, Lexington Technical Institute, sponsored the team based at Norton Children's Hospital in Louisville.

The general format for all three panel discussions was for each member to give a brief summary of their experiences in the Program. The majority of the time could then be spent answering questions from attendees. All remarks will be paraphrased in this report.

a. Mr. John Wadsworth - Louisville V.N.A.

1975 marked the second consecutive year he sponsored the team based at V.N.A. The team was composed of seven students: a Physical Therapist, Medical Technologist, Nurse,

Dental Hygienist, Pastoral Counselor, Speech Therapist and a Community Health Educator. This team spent considerable time in planning. Numerous fall meetings were called and the team spent a day with the V.N.A. prior to the January experience. Generally, most of the personality problems were overcome by getting to know each other in advance. The planning aspect was so emphasized by the students that one student, who failed to attend several meetings, was asked to withdraw from the team.

The first week in the field was spent in a community and agency orientation. Students rotated through the Metropolitan Social Services Department, spent an evening riding patrol with the Police Department and made several other visits in the Community. Considerable time was devoted to review of the V.N.A. policies, proceedures and patient records.

Though the team found the orientation activities to be benificial, by the second week they were anxious to begin provision of patient care services. During this phase students decided to spend most of their time in their own professional tasks. This led to some conflict in terms of program objectives regarding "team" and in terms of specific student difficulties in performing tasks in a Home Health environment.

Students started to fully embrace the team concept in the third week. Students paired off in their home visits and began sharing tasks. The Physical Therapist, for example,

would pair with the Speech Therapist. During the morning visits the students concentrated on patients needing Physical Therapy. The Physical Therapist could then teach the Speech Therapist the tasks, roles and responsibilities related to Physical Therapy. During the afternoon the students would concentrate visits on patients needing Speech Therapy. The same process would occur. After several such pairings the students felt a much more expanded view of other professions in addition to valuable clinical experiences in Home Health.

b. Ms. Ruth Assell - Morgan County ARH, H.H.A.

This also marked the second consecutive year Ms. Assell sponsored the team based in West Liberty. However, this was the first year a clinical team was assigned there. The team was composed of six students, a Physical Therapist, two Nurses, a Dental Hygienist, a Community Health Educator, and a Pastoral Counselor.

Upon arrival in West Liberty the team found their fall planning to be of little direct value. The Home Health Agency could provide neither the patient load nor the logistical support to follow the plan. The team then decided to form two subgroups with membership constantly shifting. One group would be based in the Home Health Agency and make home visits. The other would concentrate in school health, providing screening and educational services in conjunction with the local Health Department. A common theme joined both groups: to find families with multiple health problems which each member of the team could help solve. Once a family case load

was established, if the team could not solve the problem within the three week time frame, the cases would be referred to the appropriate local agency.

This plan met with limited success due to one major unforseen circumstance. During the first day of the second week an eight inch snow storm hit West Liberty. The town was paralyzed for three days. If nothing else, students saw the relationships between transportation systems, government services and weather in the delivery of health services.

As a faculty member in the College of Nursing Ms. Assell found one major problem related to participation in Kentucky January. Nursing students volunteer for the Program and faculty from the College must participate on a 6:1 ratio of student volunteers.

In 1975, 36 students elected to remain on campus for regularly scheduled classes and a burden was placed on remaining faculty. In an effort to lighten this burden faculty on Kentucky January video-taped their lectures. This provided the dual purpose of meeting their required lecture schedule and providing Kentucky January volunteers a mechanism for catching up on lost coursework. Students on campus need direct supervision, however, and video tape is only a partial answer.

c. Mr. Ken Martin - St. Claire Medical Center, Morehead

This was Mr. Martin's first year as a faculty sponsor. His observational team was composed of seven students: a Community Health Educator, a Dental Hygienist, a Nurse, a

Medical Technologist, a Clinical Associate, a Social Worker, and a Physical Therapist from Medical University of South Carolina.

Mr. Martin found the pre-field orientation to be extremely important. His team met three times in the fall to review concepts and finalize logistics. They were not able to make a site visit, but the location coordinator did visit the team in Lexington. She brought a slide presentation highlighting the community, its problems and the activities the team would pursue. The team had few problems while in the field and positively evaluated the experience. Mr. Martin expressed surprise at the level of change in the students and found the experience to be equally valuable to himself in his teaching activities.

The only serious problem the team encountered related to housing. The team was housed in University dormitories in Morehead. Since the dorms were not co-educational the team had to be split. As a result the team experienced difficulty in scheduling evening meetings.

d. Ms. Susan Lipscomb - Norton-Children's Hospital, Louisville.

This was Ms. Lipscomb's second consecutive year as sponsor to the team based at Norton-Children's Hospital. She felt that due to her knowledge of Louisville and the people with whom students would be dealing she could provide a better learning experience for the team. The team was composed of five students: a Medical Technologist, a Dental Hygienist, a Social Worker, a Speech Therapist and a Physical Therapist.

Ms. Lipscomb explained her view of the role of faculty sponsors. In terms of planning a sponsor must walk a very thin line. If there is too much planning and structure students rebel. If there is too little planning and structure students get bored. She provided the most structure the first week in the field. In the second week she was available but was not constantly present with the group. By the third week the team was totally on its own.

The field experience itself proved most valuable, though there were some traumatic moments. Two members contracted severe cases of the flu and one member contracted food poisoning. (All three cases were treated at a nearby family practice clinic.) The second week was the most memorable. During the hospital rotations each student was assigned a patient who was scheduled for surgery the next day. The students followed their patient through each phase of hospitalization from admission, to lab work, to surgery, to recovery and discharge.

e. Questions Posed To Faculty

1.Q. What are the positive benifits to you measured in your own professional growth?

A. One sponsor answered that he had a better perspective of other Allied Health professions. Prior to Kentucky January he had no idea of the knowledge and skills they possess. The experience also helped him in terms of dealing with others. It is a unique teaching experience.

2.Q. How did you gain the support of your spouses?

A. Three of the panel members were single. One member was married, but his wife also went on the program as a sponsor for another team in the same location. Generally there is a greater problem with married students.

3.Q. How is participation on Kentucky January related to promotion, tenure and salary?

A. Participation is unrelated to promotion and tenure. The reward was in the experience itself, the professional growth. It provides a break from routine tasks and an expanded awareness of life outside the "ivory tower". Participation also embraces the total philosophy and effort of the College of Allied Health Professions.

4.Q. Could the Program be equally successful if kept on campus?

A. It would not be as successful for two reasons. The Medical Center provides an unrealistic setting for experiencing concepts of community health services delivery. The political atmosphere at the Medical Center precludes effective teaching of team concepts. In addition, by getting students off campus the experience is intensified. Students are taken away from reference groups which could negatively reinforce the team concepts and by placing them in a "strange" environment the team naturally draws together.

5.Q. Do you feel the benifits would be the same if you took a homogenous group of students?

A. If there are seven disciplines there are seven different points of the same experience. The greatest part is in explaining what they saw.

6.Q. Why is it important for a Medical Technologist to have a broader view of other disciplines?

A. It provides a mechanism for better communication and cooperation within a setting. For example, if the technologist knows what a nurse must face each day, he will be less inclined to complain about patients being late from the floor.

A. Students who have participated in Kentucky January actually use other members of the team. They share their experiences with other disciplines. Students who have not taken Kentucky January talk exclusively in their own discipline. They say they involve other disciplines but do not.

7.Q. How long will the enthusiasm sustain faculty? What is the probability of success?

A. The idea is to go on the Program for a few years and then sit out. In this way faculty will not get "burned out". Some faculty are interested and others are not. Many times the uninterested faculty will change once he has participated in the Program.

2. Student Panel

a. Donna Campbell - Louisville V.N.A.

Ms. Campbell was a junior student in Community Health Education. Her group met several times prior to the experience.

She reports that they needed these meetings more than they realized, for they had to make their first major group decision before they left for Louisville. One member had not attended several meetings and the group had to decide whether or not to ask her to withdraw.

Ms. Campbell felt at a disadvantage going into the Program for two reasons. First, she was a junior on a team composed of senior and graduate level students. Second, her major of Community Health was difficult to explain. No one knew what a Community Health Educator could do. The real value of the experience, however, was precisely the peer pressure to overcome the insecurities. She had to perform and she had to explain her activities.

b. Robert Wagner - Somerset

Mr. Wagner was a senior in Dental Hygiene. He expressed that students learn from the Program in proportion to the effort they put into it. He was negative toward the experience at first, but resolved himself to going and ended up enjoying it. He reported that the atmosphere at the Medical Center is not as "real" as he previously thought. He was confronted with very simple questions never asked of him before and he found them difficult to answer. "What do you use if you do not have a toothbrush?"

c. Jon Walz - St Claire Medical Center, Morehead.

Mr. Walz was a first year student in the Clinical Associate Program. For him Kentucky January was probably the most intense social and professional experience he ever had.

One of the values was to explain who he was and what he did. The experience forced him to change his definition of "Physician's Assistant" almost daily. He found himself going through a period of finding a role in which he was comfortable in. Another value of the experience was learning how to relate to individuals without 'crawling behind a white coat or name tag.'

d. Theresa Clark - Harlan ARH,HHA

Ms. Clark was a graduate student in the Speech Pathology and Audiology program in the College of Education. She told of the culture shock of Harlan; the differences of values, customs, and life styles. The value of the experience however, was encountering for the first time families who needed health services but who would not seek them.

e. Questions Posed To Students

1.Q. Would this Program be appropriate for a sophomore?

A. The sophomore level is too early. A student needs a good professional background and strong motivation. A student doesn't have the professional background until his Junior year.

2.Q. Did you change your perception of other disciplines on the team?

A. Yes. After working with a Physical Therapist she saw the social aspects of the profession.

A. After returning from the experience a student had a different outlook. He realized the need to learn more about other professions because he will need them later.

A. Another student cited a case of a medical technologist who was having problems functioning on a clinical team. By the third week, however, the student was performing tests in the homes, explaining what the tests were, why they were run, and cheaper methods of running the test. Her perception of medical technology changed radically during the Program.

3.Q. Would you want to go back to your site and work for a while?

A. The general concensus was yes. These students enjoyed the slower pace and different social habits. One student remarked that on his site all employees and medical staff of the hospital got together for vollyball once a week. He didn't think this could ever happen at U.K.

4.Q. Could Kentucky January be a vehicle to inspire rural work? Would you be willing to sacrifice urban benefits for a rural workplace?

A. The general concensus was positive. Students reported that the Program showed all phases of the community. A lot of students are looking for a challenge and they often find it in smaller communities.

5.Q. What were the problems students encountered?

A. It was a very frightening experience, especially for introverted students. The students find out who on the team really wants a career and who just wants a major. Some students go only because they have to and this causes problems for the entire team.

6.Q. Who pushed you, students or faculty?

A. Students. One student would motivate others. After that it was self motivating. The program is not as moving until one student hears about it from another student.

7.Q. Did any students continue their interaction with other disciplines when they returned to U.K.?

A. Yes. The Dental Hygiene student stated that since their return to campus he has cleaned each member's teeth.

3. Location Coordinator Panel

a. Elaine Dillhunt - Coordinator of Inservice Education Harlan ARH

Ms. Dillhunt offered some random thoughts on Kentucky January experiences in Harlan. Students generally feel a culture shock upon arrival in Harlan. Life styles, values and beliefs are quite different than those encountered on campus. Site visits during the fall lessen the shock, yet it will still occur to a certain extent.

Students also seem to suffer some role conflicts within the Program structure. The roles of faculty sponsors and location coordinators need to be clearly defined and understood by all participants.

Related to the role conflict is the intense desire of students to deliver "hands-on" patient care. When the time comes to actually deliver that care a great amount of

hesitancy occurs. The students didn't quite feel "ready" for the jump and created some ingenious excusses to delay their first patient encounter. Some excuses were not so ingenious. One student simply locked himself in a room for a day.

There is never adequate time to gain the full benefit of the experience. For example, the image of Harlan is bad. The word "Harlan" conjurs up such images as bootlegging, gambling, coal, unions, "Bloody Harlan". In the short three weeks of Kentucky January students do not really see a true picture of the area.

The major benefit of Kentucky January for Harlan A.R.H. is the exposure of the hospital staff to the teams approach to health care. The atmosphere of the Program is contagious. The staff, by observing a team in action, cannot help but benefit from the experience.

b. Mr. Rick Schuster - Director of Public Relations
Jewish Hospital of Louisville.

There must be planning among the hospital. Public relations should be improved. Never allow yourself to be surprised. Never give a department head an excuse to surprise you. Planning within the hospital should be balanced. For example, there was no planning for lunch and this disrupted the students. The students had to learn to plan for themselves. By the third week the students had no hesitancy to go back to the department heads and plan for themselves.

He was not happy with the coordination at U.K. The group started late. There is a need to know what the student's expectations are and what orientation is needed.

The hospital was not informed properly about when to expect the team. The location coordinator had to set up things in town all themselves. He felt that the teams were short changed. Arrangements were poorly made.

There is potential for enrichment. The students should view, for example, the delivery of a child.

The relationship between the faculty sponsor and students is very important. It is good to orient the students, faculty sponsor and location coordinator in advance.

c. Sr. Luann Bender - Medical Technologist, St. Claire Medical Center, Morehead

This was Sister Luann's third year with the Program. She commented on the varied nature of her three teams ranging from highly motivated and stimulating to lax and destructive. She used these experiences to point out that no guarantees can be given a team site regarding the quality of the students. Sometimes, for unknown reasons, the teams simply do not work out. When teams don't work out, however, the job of the location coordinator is most difficult in terms of changing the attitudes of local participants.

On the other end of the scale, the Program has brought positive benefits to Morehead. The hospital has been successful in recruiting Kentucky January students. The first year a Medical Technologist was recruited for the laboratory.

Other students, as a result of their Morehead experiences, have made personal commitments to rural health and to home health as career paths.

The teams have provided a stimulus to the staff. The fresh ideas and new skills have challenged the staff to improve their own skills.

There was some concern over having two Kentucky January teams in a site the size of Morehead. In 1975 a clinical team was attached to the Hospital's home health agency. Hospital personnel feared the chaos of two teams competing for agency experiences.

The Program proved generally successful for both teams in 1975. The fears of competing teams proved unfounded due to the differing approaches of the clinical and observational teams. The St. Claire Medical Center is looking forward to continuing with both teams in 1976.

d. Sr. Ann Marie Falloon, Director, St. Claire Medical Center HHA

This was Sr. Ann Marie's first year with the Program, and she reported that the home health agency experienced the "growing pains" of any new Kentucky January site. The staff was not fully prepared for the demands to be placed on them by the students. As a result there were some "rough spots" in arranging logistics and finding experiences for students.

Some students had a rough time in the home health setting. The structure and equipment normally used by students could not be used in home visits and some students could not

accomodate to it. By the end of the three weeks, however, all participants found the experience to be a positive one.

The staff responded very positively to the clinical team. They felt a sense of accomplishment in stimulating the students to experiment in new directions. The staff felt a stimulation from the students. They inserted a new energy to the agency's activities.

The faculty sponsor and agency staff learned much from this first clinical team. They look forward to refining the experiences for the 1976 Kentucky January team.

e. Questions Posed to Location Coordinators.

The question period for Coordinators had to be cut short due to the time constraints of the Workshop program.

IX. Summary and Evaluation

The objective of this conference was to fully acquaint participants with the conceptual and operational details of interdisciplinary education in allied health as carried out in the Kentucky January prototype. Over a three day period the participants were given massive amounts of information verbally and in written forms. They were allowed to question participants in the program, students, faculty, and location coordinators, as well as provide input themselves to future planning.

In general the attendees were surprised at the complexity and depths of the Kentucky January program, but they did complain that the conference presentation was too detailed and compacted. In all they were pleased with the conference and felt that the time commitment was well worth their effort.

Attendee concerns relating to implementing a Kentucky January prototype on their own campus centered on available dollars, scheduling problems, and in some instances ideology problems. However each participant was interested in working towards the implementation of such an effort on their own campus in spite of obstacles.

5:00 p.m.	DAY'S END
7:00 p.m.	Dinner BARN DINNER THEATER

Thursday, April 17, 1975

8:45 a.m.	PARTICIPANT PANELS - Faculty Panel - Student Panel - Location Coordinator Panel
10:30 a.m.	BREAK
10:45 a.m.	RESUME REPORTS AND FINAL QUESTION AND ANSWER PERIOD
12:00 Noon	LUNCH
2:00 p.m.	THE SPORT OF KINGS (at your option)

50/1975

WORKSHOP OBJECTIVES:

This workshop is being presented to fully acquaint participants with the conceptual and operational details of interdisciplinary education in allied health as carried out in the Kentucky January prototype. At the conclusion of the meeting, participants will have the knowledge necessary to replicate this model on their campus. The ultimate objective is that a Kentucky January type program be initiated on the campus of the participants.

FACULTY:

Joseph Hamburg, M.D., Dean, College of Allied Health Professions

Thomas F. Connelly, Jr., Director, Office of Special Programs

Daniel A. Clark, Assistant Director, Kentucky January Project

University of Kentucky College of Allied Health Professions faculty and students who have participated in Kentucky January

Local people who have participated in Kentucky January

Workshop On

Interdisciplinary

Education

Kentucky January Prototype

Partially Supported By:
DIVISION OF ASSOCIATED HEALTH MANPOWER, DHEW
Contract #231-75-0204

UNIVERSITY OF KENTUCKY

COLLEGE OF ALLIED HEALTH PROFESSIONS

APRIL 15 - 17, 1975

CARNAHAN CONFERENCE CENTER

LEXINGTON, KENTUCKY

UNIVERSITY OF KENTUCKY

COLLEGE OF ALLIED HEALTH PROFESSIONS

WORKSHOP ON
INTERDISCIPLINARY EDUCATION

PROGRAM OUTLINE:

Tuesday, April 15, 1975

5:00 p.m. Kentucky Get Together Hour

6:30 p.m. Welcome dinner, introduction of workshop objectives and format, video tape review

Wednesday, April 16, 1975

8:30 a.m. Overview of Existing Interdisciplinary Programs:

- Basic Concepts (materials - Interdisciplinary References, published by UKCAHP, mimeographed 1975)

8:45 a.m. PROGRAM CONCEPT DEVELOPMENT

- Objectives
- Administrative Considerations
- Field Logistics

(materials - internal memos, procedures, schedules, budgets, contracts, etc., prepared by Kentucky January staff)

10:00 a.m. BREAK

10:15 a.m. PROGRAM CONTENT

- Observational Team
- Clinical Team

(materials prepared by Kentucky January staff)

12:00 Noon LUNCH

1:00 p.m. FACULTY DEVELOPMENT

- Faculty Issues
- Teaching Program
- Teaching Materials

(materials: manuals, bibliographies, transparencies, slides, etc., prepared by Kentucky January staff)

2:00 p.m. STUDENT DEVELOPMENT

- Teaching Program
- Teaching Materials

(materials: manuals, bibliographies, transparencies, slides,etc. prepared by Kentucky January staff)

3:00 p.m. BREAK

3:30 p.m. LOCATION COORDINATOR DEVELOPMENT

- Teaching Program
- Teaching Materials

(materials: manuals, transparencies, slides, etc., prepared by Kentucky January staff)

4:00 p.m. EVALUATION METHODOLOGY

- Formats
- Instruments
- Results

(materials: reports, instruments, developed by Kentucky January staff)

WORKSHOP ON INTERDISCIPLINARY EDUCATION
Kentucky January Prototype
April 15-17, 1975

PRESENTATION OUTLINE

TIME	TOPIC	CONTENT	MATERIALS
April 15, 1975			
5:00 P.M.	Cocktail Hour		
6:30 P.M.	Welcome Dinner	1. Introduction of Workshop Objectives and Format	1. 1974-75 Study Guide and Resource Manual 2. 1973-74 Program Report 3. Workshop Presentation Outline
April 16, 1975			
8:30 A.M.	Overview of Existing Interdisciplinary Programs (red tab)	1. Research 2. Generic Models 3. Development Issues	4. Interdisciplinary References
8:45 A.M.	Program Concept Development (white tab)	1. Objectives of Kentucky January a. Health Care Environment b. Team	5. Institute For Health Team Development NEWS, February, 1975 (REFERENCE: Study Guide and Resource Manual, P. 1-2)
		2. Administrative Considerations a. Organization: Internal 1. College-wide vs. Departmental 2. Budgetary Considerations External 1. Program set-up 2. Faculty Responsibility for Teaching Team 3. Staff Support	(REFERENCE: Study Guide and Resource Manual, P. 3-5)

TIME	TOPIC	CONTENT	MATERIALS
		b. Finance: Source of Funds Distribution of Funding 1. Categories 2. Students 3. Credit Hours	6. Financial Reports
		c. Communications: Internal 1. Department Chairmen 2. Faculty 3. Students 4. Other Colleges	7. "Kentucky January Issues and Planning for 1976"
		External 1. Administrators 2. Location Coordinators	8. Kentucky January News 9. Kentucky January General Information Flyer
		d. Program Timing: Length University Calendar Letter to Students	10. Admissions Letter
		e. Public Relations: Press, Photos Kentucky January society Certificate of Affiliation Thank You Letters a. Newspapers b. Affiliates As Relates to site Development	11. Sample Press Releases 12. Sample of Certificate 13. Sample letter and Certificate 14. Sample of Letter 15. Sample of Letter

TIME	TOPIC	CONTENT	MATERIALS
		f. Academic Considerations: Course Description and Level Faculty and Departmental Commitment Campus Problems a. Late Registration b. Fee Payment c. Campus meals, housing d. Missed coursework Control of Content/Input	16. Copy of Course Description (REFERENCE: "Kentucky January Issues and Planning for 1976" (#7 white tab)
		3. Field Logistics a. Living Arrangements: Housing Food Cost/Payment	17. Housing Contract 18. "Kentucky January Motel Billing Instructions" 19. Copy of Memo to Faculty (REFERENCE: Financial Reports) (#6 white tab)
		b. Transportation: State Cars Personal Cars Costs/Payment	20. "Regulations and Procedures Concerning Use of Autos on Official Business" (REFERENCE: Financial Reports (#6 white tab)
		c. Contractual Arrangements: Clinical Facilities	21. Facilities Contract
10:15 A.M.	Program Content (Blue Tab)	1. Observational Teams a. Objectives: Weekly Divisions b. Program Elements: Facilities	(REFERENCE: Study Guide and Resource Manual, P. 3, P.6-9 22. "Kentucky January Location Site Activities Guidelines January 1974

TIME	TOPIC	CONTENT	MATERIALS
		c. Resource People: Chamber of Commerce Elected Officials	23. "Local People Participation"
		d. Time Commitment: Fall Meetings	
		e. Student Selection Process:	24. "Student and Faculty Participation; A 3 year Summary"
		Meetings	25. "Tentative Schedule of Student Activities; Observational Teams"
		Sign-up	26. "Student Information Questionnaire"
		f. Logistics:	27. "Team Site Checklist" 28. "Kentucky January Team Site Information"
		Scheduling Team Composition Student Transfer	29. Sample Team Schedule 30. Transfer Procedure
		g. Project Activity: Reports	
		h. Continuing Education/ Consulting	31. "Continuing Education and Consulting Report--Kentucky January 1975."
	(Red tab)	2. Clinical Teams a. Objectives	32. "Kentucky January Clinical Team"

TIME	TOPIC	CONTENT	MATERIALS
		b. Guidelines	(REFERENCE: "Kentucky January Issues and Planning for 1976", P.6) (#7 white tab)
		c. Faculty Selection d. Student Selection e. Time Commitment: Fall Meetings f. Activity Areas: Home Health, Schools Day Care g. Logistics: Cars h. Consulting and Patient Care	33. "Tentative Schedule of Student Activities; Clinical Teams" 34. "Morehead Clinical Team Repor (REFERENCE: "Continuing Educatio and Consulting Report--Kentuc January 1975")(#31 blue tab)
12:00 Noon	Lunch		
1:00 P.M.	Faculty Development (yellow tab)	1. Selection a. Definition of Role b. Ratio	35. "Considerations on Being a Kentucky January Faculty Sponsor" 36. "Skills of Effective Kentucky January Faculty Sponsors" 37. Student Evaluations of Faculty Sponsors 38. "Evaluation of Kentucky January" By Ralph Carpenter
		2. Issues a. Time Commitment: Campus Field b. Overload: Compensation	39. "Facult Time Survey" (REFERENCE: "Kentucky January Issues and Planning for 1976" P. 8) (#7 white tab)

TIME	TOPIC	CONTENT	MATERIALS
		3. Teaching Program a. Objectives b. Scheduled Meetings c. Past Approaches d. Content: Learning Environment Materials	40. "Tentative Faculty Meeting Schedule" 41. "Kentucky January Teaching Tools and Techniques"
		4. Evaluation a. Staff b. Students	(REFERENCE: "Kentucky January Issues and Planning for 1976") (#7 white tab) (REFERENCE: Student Evaluations of Faculty Sponsors) (#37 yello tab)
		c. Letter of Recognition	42. Copy of Faculty Letter of Recognition
2:00 P.M.	Student Development (Green tab)	1. Issues a. Voluntary vs. Mandatory b. Grading Process: Undergraduate Graduate	43. Grade Form 44. "Average Grade Scores by Discipline and Question Numbe (REFERENCE: "Kentucky January Issues and Planning for 1976" p. 2 and 3) (#7 white tab)
		c. Dropouts	45. "Kentucky January Student Participation by Department"
		d. Class Time e. Social Activity 2. Teaching Program a. Schedule b. Content: Teaching Objectives Teaching Team Teaching the Health Care Environment	(REFERENCE: "Tentative Schedule of Student Activities") (#25 blue tab)

TIME	TOPIC	CONTENT	MATERIALS
		c. Orientation: Objectives Content	46. "Kentucky January 1975; Orientation Program" (Agenda) 47. "Kentucky January 1975; Group Problem Solving Game" 48. "Kentucky January 1975; Group Concensus Seeking Game"
3:30 P.M.	Location Coordinator Development (pink tab)	1. Site Visit 2. Selection Process a. Type of Person: Urban Rural 3. Faculty Appointment a. Time Commitment	49. Curriculum Vitae Form 50. Copy of Letter of Appointment 51. "Location Coordinator Time Survey"
		4. Training Program a. Fall, Spring b. Content	52. Agenda for Fall Location Coordinators Conference 53. Agenda for Location-Coordinator-Faculty Sponsor Evaluation Meeting 54. "Issues--Clinical Teams" 55. "Issues--Observational Teams"
		5. Recruitment	
4:00 P.M.	Evaluation Methodology (tan tab)	1. Objectives 2. Formats a. Dates b. Administration	56. Kentucky January 1975: Evaluation Methodology and Results

TIME	TOPIC	CONTENT	MATERIALS
		3. Instruments a. Quantitative b. Qualitative	
		4. Results a. Quantitative b. Qualitative	57. "Kentucky January Experience" by Kay Liebman 58. "Kentucky January Experience" by Theresa Clark 59. Evaluation Computer Program and Explanation (REFERENCE: "Evaluation of Kentucky January", by Ralph Carpenter) (#38 yellow tab)
		5. Intangible Results a. Recruitment b. "Spin offs"	60. Copy of Letter from Visiting Nurses Association 61. Copy of Letter from Harlan HHA
5:00	Break		
April 17, 1975			
8:30 A.M.	Participant Reports	1. Faculty Panel 2. Student Panel	
10:00 A.M.	Break		
10:20 A.M.	Participant Reports	1. Location Coordinator Panel	

WORKSHOP ON INTERDISCIPLINARY EDUCATION
KENTUCKY JANUARY PROTOTYPE -
April 15 - 17, 1975
CARNAHAN CONFERENCE CENTER
UNIVERSITY OF KENTUCKY
COLLEGE OF ALLIED HEALTH PROFESSIONS
LEXINGTON, KENTUCKY

ATTENDEES

1. Martin H. Rosenfield, Ph. D.,
   Assistant Dean
   School of Allied Health Professions
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APPENDIX 3 CONFERENCE PARTICIPATION

WORKSHOP ON INTERDISCIPLINARY EDUCATION
KENTUCKY JANUARY PROTOTYPE
April 15 - 17, 1975
CARNAHAN CONFERENCE CENTER
UNIVERSITY OF KENTUCKY
COLLEGE OF ALLIED HEALTH PROFESSIONS
LEXINGTON, KENTUCKY

CONFERENCE PARTICIPANTS

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APPENDIX 4 CONFERENCE EVALUATION

EVALUATION FORM
CONFERENCE ON INTERDISCIPLINCY EDUCATION
KENTUCKY JANUARY PROTOTYPE
CARNAHAN HOUSE
UNIVERSITY OF KENTUCKY
APRIL 15 - 17, 1975
(16 of 18 participants reporting)

I. CONFERENCE PROCEDURE

1. Did the Conference meet your expectations?

1. Yes, however, this should be qualified by stating that expectations were not developed to any significant degree. Brief glimpses of the Kentucky January Program offered at various meetings had given some insight into goals, objectives, procedures, etc. to the extent at least, that the program philosophy was known although not in depth.

2. Yes, In fact, I didn't expect as much factual material.

3. It more than met them.

4. Yes, it was far more comprehensive than I had expected. Kentucky January is also much more complex than I realized.

5. Yes.

6. More so.

7. Pleasantly surprised. Exceeded expectations, a real learning experience.

8. Yes, exceeded.

9. Yes, it exceeded.

10. Yes, but I would like to have had small group meetings with the other conference members to discuss and exchange ideas about putting this into operation at the various schools.

11. Yes.

12. Yes, more than my expectations.

13. Yes.

14. Yes.

15. Generally yes although I would have liked more time to talk with other participants about programs at the schools they were representing. The emphasis in process and the pragmatics of implementation was useful.

16. Yes, it certainly did.

2. Were the materials appropriate to the objectives?

1. Yes.
2. Yes.
3. Yes.
4. Excellent
5. Yes
6. Yes
7. Will need additional time to digest the voluminous materials offered, cursory view suggests that the materials presented are appropriate.
8. Absolutely
9. Yes.
10. Yes, in a way we received more material than was needed to understand the ramifications of the Program. I appreciate receving the detailed materials however.
11. Yes, and they were well organized and presented.
12. Yes, the project has developed some excellent preliminary material. The only material that I question are the evaluation data.
13. Yes, although there has been too little time available to "digest" all that has been offered as written material, the portion of the program (eg. the conference) that exposed the heart and soul of the effort came thru during the final day.
14. Yes, they significantly reinforced my wishes for the program we are developing.
15. Yes very well organized. I would suggest shortening the video tapes shown the first evening.
16. Yes, the handout materials were quite heloful, however, I would have appreciated summaries of the sometimes rather lengthy documents.

3. Were the speakers well informed?

1. This was expected from the staff. However, the reward came from the coordinators, students, etc. No negativism intended as directed toward staff but the most meaningful portion was the "confession periods".

2. Fine, selection of the individuals on the three panels was outstanding.

3. Superbly.

4. Yes, without a doubt the people of Kentucky January are well organized, well founded and eat and sleep their work. I am sure they could use a pat on the back to keep them going at times.

5. Yes.

6. Definitely and importantly enthusiastic.

7. To be commended for their intimate knowledge of the program.

8. Superior.

9. Yes, but more pointedly, they were honest in their views and aspirations.

10. Yes, but I feel that they could have explored some of the questions a little more with group exchange of ideas.

11. Yes.

12. Of course! Most helpful to have the working participants available.

13. Provided <u>too much</u> information. Should have been distilled.

14. I especially appreciated their enthusiasm and frankness. The ability and willingness to present negative experiences with <u>positive</u> suggestions was particularly helpful to me.

15. Yes - quite on top of their program.

16. The speakers were, indeed, well informed.

4. Were the facilities conducive to a good meeting atmosphere?

1. Yes.

2. Yes, very pleasant, comfortable, friendly, etc. Isolated enough to be fully conducive to a good learning experience.

3. This was like coming home to Carnahan House, so I was completely in harmony with this facility.

4. Excellent.

5. Beautiful facilities. I have now been to the University two times and still haven't seen the University or Lexington. This is not criticism it is a tribute to the quality of professionals at the University of Kentucky and the effort they put forth when visitors come for professional help.

6. Yes.

7. Yes, very much so.

8. Yes.

9. Good/ excellent.

10. Yes, it was fine for me. Those from the city may have preferred a shower. Harlan has less.

11. Yes.

12. Yes. (A few showers at Carnahan would have helped).

13. Yes, lovely.

14. The warmth at Carnahan House helps to create a "group".

15. Very much so! The food and rooms were excellent. Carnahan House is a beautiful setting for a conference.

16. Yes, the Carnahan House is a pleasant conference center.

5. If this conference were to be repeated, what changes would you suggest?

1. Distill, distill, distill! Also create or allow more formal interaction between conference members.

2. Heavier emphasis on testimonials from participants in the Kentucky January experience.

3. The first day is too long, too much material. You need to select the priority material and use this only. Need more time for questions and interaction of the participants. That's what made this morning so much better.

4. I think it could have been longer, another half day (or even one more day). The size of the group was ideal.

5. Wednesday was too long in the same room with the lights too low. Otherwise no change.

6. More frequent breaks, opportunities for small inter-group exchanges.

7. Would it be possible to have some extended rap session with the students, faculty and location coordinators.

8. Yes, but I would like to have had small group meetings with the other conference members to discuss and exchange ideas about putting this into operation at the various schools.

9. It has served it's intended purpose and objective. A vote of appreciation to Kentucky, Joe Hamburg and his staff.

10. Break the information sessions with a period to let the participants take the model presented and "exchange" on "small groups" how an interdisciplinary approach could be implemented on their campus. This would extend the workshop another half day but the "application time" is a component worth considering.

11. A-more breaks in the structured components of the program design. B-student, faculty, coordinator interaction in around-table format.

12. Information overload existed; much too much on Wednesday. Could have compressed information given to half as much; much of written material self-explanatory. This was a knowledgeable group of people and a lot of sharing of information could well have taken place which would have been helpful for all-Kentucky January and group included.

13. Perhaps a bit more audience participation on the first day. Interchange of ideas rather than listening to lectures would provide a more pleasant and perhaps valuable learning experience.

14. More time for group discussion.

15. More time for discussion among participants, perhaps omit the play after dinner. Put panels earlier in program - they were very helpful yet we didn't have time for much discussion with panel members.

16. a. That the conference be limited to a one-day conference or that it would be de-compressed into a full two days. I found the heavy speech format gets to be expremely tiring. Most people felt, as I did, that the opportunity to ask questions and to clarify points would have been very helpful. Although questions were requested, it was usually one minute before the break and everyone was anxious to stretch. Consequently, little time was given to discuss the items in-depth.

    b. It would have been helpful if small groups were used with a staff member present in which we could have discussed potentials for applying this kind of Kentucky-January program at our own institutions.

II. KENTUCKY JANUARY PROTOTYPE COMMENTS

1. What suggestions would you make to modify the existing Kentucky January prototype as has been presented during this Conference?

   1. I've got to think about this. It's too easy to give gratuitous advice.

   2. This can best be assessed after further review of materials and reflection upon all that has been said and offered.

   3. The first day is too long, too much material. You need to select the priority material and use this only. Need more time for questions and interaction of the participants. That's what made this morning so much better. I'd like more discussion of the problems of future findings, etc.

   4. I think the prototype is fine, but individual campuses will have unique problems reguiring changes if it were to be implemented (e.g., administrative structure might create problems among and/or between schools, departments. The concept, however, blows my mind and I am 100% in support. You didn't ask a question leading to this response, however: 1. Your enthusiasm, hospitality, and hard work were greatly appreciated. 2. Your program is successful because of its leadership and of your excellent staff. Everyone seems to function effectively individually and as a group. 3. I'm impressed with your honesty. 4. Many thanks for a great experience.

   5. Add a 4th year Medical and a Dental student to each team.

   6. Perhaps a week long observational type program earlier in the student's academic career followed by the more intense thing at the appropriate point in their training.

   7. A-Develop interdisciplinary session (for credit) for all health related students within the medical center to tie into Kentucky January.

      B-Form the team in the semester prior to Kentucky January so that certain functions could be performed.

      C-Orientation of students; development of student expectations.

   8. I would try and have care delivered as model health teams and learn about each other by working together. I would also make the experience at least one month. Consider all teams as "hands on" - clinical teams.

   9. Earlier health careers orientation role as Freshmen. Sophomore-observation perhaps. The third year clinical teams (senior year). Extend the orientation to additional faculty members.

10. Too short of time and exposure to assess and then suggest changes. This could best be accomplished through faculty, participating students and the location coordinators.

11. Look at "spin off" possibilities suggested at the conference.

12. Answered before as information overload existed; much too much on Wednesday. Could have compressed information given to half as much; much of written material self-explanatory. This was a knowledgeable group of people and a lot of sharing of information could well have taken place which would have been helpful for all-Kentucky January and group included. The interchange with faculty, students and coordinator; really, really the meaty part and with just a half day preparetory session of information given could have been incorporated into the first day. Need to hear from students and faculty who were not enthusiastic about the experience.

13. I think students from medicine and dentistry should be genuinely encouraged to participate. Perhaps students could be better oriented to the health care delivery system prior to going, possibly via reading.

14. None - I simply wish I could copy some aspects of it.

15. I would be interested in some systematic follow-up on Kentucky January participants to determine if they perform differently than non-participants following the experience eg. choice of job setting following graduation; utilization of other disciplines on referral basis during clinical work during final semester in school, etc.

16. In addition to the responses made relative to Number 5, I would vary the format by bringing in the faculty, students and community coordinators earlier in the program to break up the conference. I would also suggest that you make better use of your audiovisual material. Also, 1) Don't turn off the room lights when using television; 2) Turn off the 2x2 projec when not in use - the lighted screen is distracting and the fan is noisy; 3) use only readable slides.

III. PROGRAM IMPLIMENTATION

1. Do you feel that you now have enough information to begin implimenting a Kentucky January prototype program on your campus?

   1. From you yes, need information about our place.

   2. Indiana has a Kentucky January in a modified form relating to individual disciplines. Adaption is certainly a possibility. Total acceptance would not be feasible. Philosophically, conceptually and functionally the Kentucky January program can significantly improve the potential of an already functional program in Indiana.

   3. Yes, but our setting will require some unique solutions. The background information here will be invaluable. Giving me the opportunity to bring an administrator along has been a great plus. Try to get more administrators here. The action people are important, but they need administrative support.

   4. Yes, I also know how much work it will be!

   5. I have enough information to be dangerous. Yes, I have enough information from which to plar. If we start a program of this type we will depend on Dan and Tom for help.

   6. Information, yes, a different approach would probably be involved in terms of our programming but with components from Kentucky January.

   7. Yes.

   8. Yes.

   9. A good feel. Can we call on you for expanded experiences?

   10. Surely but could this component get started on a small way by letting the two representatives from a campus discuss ideas - often there will be more time while off campus than when back on campus to begin to jell ideas.

   11. Yes.

   12. Yes, will need funds tho because it is obvious coordinating this task cannot be superimposed on full work load of one person.

   13. Yes.

   14. More than enough information. I need the commitment of the faculty and clinics.

   15. Probably - the proof would of course be in the pudding.

   16. More than enough.

2. What barriers do you forsee on your home campus that would hinder the implimentation of a Kentucky January prototype in your college?

1. The cost factor would be a barrier unless extramural funding could be obtained. With almost three times the number of students, the logistical problems would be intensified as well. It is not a barrier, but a different interpretation of "health team" would necessitate a more structured, clinically oriented approach.

2. A-funds
B-available time and fac. related to above.

3. Lack of clinical facilities. Too much reliance on Basic Science Faculty - how to get them off the campus. Released time, department chairmen, financial resources!

4. No answer.

5. Some budget restrictions. Some barrier identified in these discussions, but all in all believe it can happen.

6. It would be very hard to get departments to give up time for the students to get involved. I question that the university is ready to move this way.

7. Finances, ideology.

8. Our people are not at comparable points in their programs in terms of clinical background at any one point of time in the year--quite a few gaps in our current curriculum scheduling.

9. The Vice-President and President have no appreciation for health programs and the academic and financial support required to make a program of this type go. We have the support at the Dean's level but not at the higher levels.

10. I see some insular departments so caught up in the status quo as "fighters". Also there could be some dean problems (might feel that some power was being usurped).

11. Funding, not just grants but future funding. Some of our faculty will be negative to new programming but we have a nucleus that should make this happen.

12. Money - people - time - to cite just a few!

13. Schedules.

14. Refusal of programs to revise their schedules.

15. A. We are committed to involving medical students in any interdisciplinary endeavor but one major harrier is the schedule difference between the college of Allied Health and Med. School.

B. Faculty sponsors - most programs are understaffed and I would anticipate problems in getting faculty to give time.

C. Philosophical differences among departments.

16. Primarily financial. Our main obstacle would be to find resources to provide us with the money to hire a program coordinator, which I think is absolutely essential to the success of the program.

3. What additional services could the conference faculty provide to assist you in the implimentation of the Kentucky January prototype on your campus?

1. I'll be in contact.

2. For the moment none. There must be a local educational process evolved to promote an attitudinal change in faculty and staff before external support would be meaningful. Thanks for an excellent conference and exceptionally fine hospitality.

3. Consultation and we won't be afraid to ask. Thanks for an excellent conference.

4. I'm not sure now but we know where to go for answers, right?!

5. Consultant services. Kentucky People are beautiful. Thanks for everything.

6. Not sure, if we were to become involved seriously I might like the enthusiasm to be imported on a faculty to faculty basis thru conference workshops.

7. On-site consultation!

8. Be able to come to the university and talk to meeting of deans, etc.

9. A-some consultation
B-moral support.

10. Consultation; repeat the conference to expose those from the same institutions/campuses invited to this conference.

11. The need to impress on our administration the support for the activities of an appropriate office of special programs, to conduct a program of this type.

12. Nothing at moment but when we become involved, I hope they'll be available for further questions.

13. Perhaps consultation in the future.

14. Opportunity to use:
    1) tapes of evaluation conference
    2) possibly consultation services on program changes

15. If we should choose to try to implement the Kentucky January prototype, I would see direct consultation about logistical issues as they arise as being most useful, eg. 1-2 day consultation.

16. I could think of no services at this point that would be needed to facilitate program implementation at Ohio State University.

Kentucky January Prototype Conference
Appendix 5
Bibliography of Materials

The conference attendees were each given a loose leaf binder of some two hundred pages of in-house memoranda, forms, letters and other materials relative to the program operation. These materials are outlined in Appendix A, "Presentation Outline" under the materials heading.

There are also other published documents from which conference presentations were drawn and references made available.

1. "Interdisciplinary References II," Tom Connelly, Jr. Office of Special Programs, College of Allied Health Professions, University of Kentucky, Lexington.

2. Kentucky January-Study Guide, Kentucky January program office, University of Kentucky, College of Allied Health Professions, Lexington, Kentucky.

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10. "Kentucky January - One More Approach to Interdisciplinary Education," Tom Connelly, Jr., Health Team News, Institute for Health Team Development, Feb. 1, 1975.

INTERDISCIPLINARY REFERENCES III

A Reference Document For Those Contemplating Interdisciplinary Educational Programs In The Health Sciences

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July 1975

INTERDISCIPLINARY REFERENCES III

C O N T E N T S

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I. INTRODUCTION

Interdisciplinary education has become a "buzz word" of health science educators. Unfortunately, there has been little analysis of the varying formats and approaches to this emerging endeavor. Through our experience at the University of Kentucky it can be positively stated that while most educators can agree that interdisciplinary education is necessary there is widely divergent interpretation of what is interdisciplinary education and what should be its objectives.

This document is prepared as a PRIMER for those who are looking for approaches to interdisciplinary education activities in the health sciences.

It contains four basic sections which present concepts or tools which the author believes to be important to those who are considering the implementation of interdisciplinary programs. There is also no presumption on the part of the author that all questions and/or answers to interdisciplinary programing may be found in this work. Each situation for interdisciplinary education differs thus likewise, the approach to the program.

By virtue of the dynamic nature of the burgeoning interest in interdisciplinary education this document is incomplete at its printing. However, if used as intended as a reference, it should provide some insight into programing problems and solutions.

Many people have shared information on their programs with us to make this document possible - to all of them goes much thanks.

This document is made possible in part through Special Projects Grant 5 D12 AH00220-02, of the Division of Allied Health Manpower Bureau of Health Manpower National Institutes of Health, Department of Health, Education, and Welfare.

II. GENERIC MODELS OF INTERDISCIPLINARY EDUCATION IN HEALTH SCIENCE PROGRAMS

Interdisciplinary Educational activities in the Health Sciences are more abundant than anticipated if its definition is presented in pure generic terminology. To this author's knowledge one of the first systematic attempts to present a generic overview of interdisciplinary education in Health Science was made by Richard B. Fox, a medical student at the University of Minnesota, Minneapolis. Fox described five generic models of interdisciplinary education based on his research of existing programs in the literature.

Taking his original approach a case may be made for describing four instead of five true generic models of existing health science interdisciplinary education activities.

Examination of these models is important as the planning organizational approach to each of them will differ. The chart summarizes the characteristics of each of the models, but some comment on each is appropriate.

I. Traditional Model

This model is found in some format in almost all health science teaching centers. It is generally a multidisciplinary content course or subject which is taught to a mono-discipline group of students. It is interdisciplinary from a faculty or teaching standpoint. Common topics might be Epidemiology or, Legal Medicine.

II. Common Interest Model

More and more the common interest subject format is being taught in the health science center. In terms of a defined health

profession (physical therapy, nursing or respiratory therapy) this is generally a "non-disciplinary", topical subject course or program such as Problems of Health Care Delivery or Financing of Health Care. Within the scope of this model might also be taught "core" courses in the behavioral or physical sciences. The students and faculty could be interdisciplinary.

III. Case Presentation Model

Generally this type of interdisciplinary activity can be characterized as a passive patient centered activity through the relation of some element of academic study to an actual patient. It may be used in an interdisciplinary or monodisciplinary setting of faculty and/or students. Typically the problem will be related to a disease or social oriented continuum of a patient.

IV. Health Team Models

This form of interdisciplinary education is perhaps the one which receives the most attention as well as the most misunderstanding. The Health Team Model is essentially distinguished from the preceeding three models by the major emphasis on students from several disciplines sharing some joint responsibility for a task which requires mutual cooperation to achieve a stated goal. That one distinction is the last major characteristic that various Health Team Models have in common.

Health Team Models can be subdivided into two generic team approaches - Research Team and Patient Care Team. The Research Team approach is one in which student teams study a particular problem through research methodology. This might be a community survey or a study of the state of the art of some aspect of Health Care Delivery.

The Patient Care Team Model Approach which declares responsibility for providing health care jointly as its major characteristic can be further subdivided into two approaches - Professional Orientation and Patient Orientation. These two models while using care of the patient as the central focus differ in their objectives. Professional Orientation programs are generally built around proscribed disciplines with the major objective being to assist those prescribed disciplines in learning to relate to each other through the patient's needs. On the other hand, the Patient Orientation Team models develop the team approach through the patient's needs incorporating the necessary disciplines as the time arises.

The decision of which of these models or their variations to implement in a given teaching program must be based upon the learning objectives desired by the faculty. Too often the interdisciplinary concept is accepted blindly as a "holy" idea and embarked upon without the necessary examination or explanation of its ultimate purpose. Compounding the problem of inadequate or misunderstood rationales for interdisciplinary activity is an expectation that the formats of the preceeding models will adequately prepare the student to function in a "team" approach.

Each of the preceeding models has some value in the preparation of the health science student to function in a conjoint practice format, but the relationship of these models to the behavioral results expected must be clearly understood in terms of domains of human learning.

By coupling the learning domains and models of interdisciplinary activity the educator can begin to develop a realistic set of learning objectives and therefore expected results for interdisciplinary activities. It should be quite evident that the Traditional and Common Interest models are prime examples of the cognitive domain process while the Case Presentation and Health Models reflect very actively the elements of the psycho motor domain. Interpretation of the affective domain as one in which attitude or value systems are determined one might say that the objectives for this domain must be constructed to coincide with both cognitive and psycho-motor objectives in any of the four models. There, perhaps, is no clear cut distinction between the three domains indicating that effective interdisciplinary education requires the complete application of these principles regardless of the model utilized.

The implications of applying these elements of human learning goes beyond any attempt to match learning objectives with prescribed models of activity. It indicates that interdisciplinary education is a complex unique learning methodology and that if it is to be applied in the health science area to improve the care of patients, recognition must be given to the fact that it is a continuum of learning experience from cognitive to psycho-motor!

GENERIC MODELS OF INTERDISCIPLINARY HEALTH SCIENCE PROGRAMS*

	DISTINGUISHING CHARACTERISTICS	CONTENT	STUDENTS	FORMAT	COMMON TOPICS
I. TRADITIONAL MODEL	Primarily Interdisciplinary from a teaching standpoint	Multidisciplinary	Unidisciplinary	Lecture, discussion, etc.	1. Epidemiology 2. Legal Medicine
II. COMMON INTEREST MODEL	Topics related to common science requirements or "non-technical" aspects of health	Nondisciplinary (relative to health professions) Topical	Multidisciplinary	Lecture, discussion, seminar	1. Problems of Health Care Delivery 2. Financing Health Care 3. Moral and Ethical Problems 4. Anatomy
III. CASE PRESENTATION MODEL	Passive patient centered activity through relation of academic study to actual patient	Interesting Cases demonstrating principles of interdisciplinary comprehensive care	Uni- or Multidisciplinary	Clinical Case Conference	1. Disease Oriented 2. Social History Oriented 3. Rehabilitation Oriented
IV. HEALTH TEAM MODELS					
1. RESEARCH TEAM	Students from several disciplines share joint responsibility for some task which requires teamwork	Study a particular problem through research methodology	Multidisciplinary	Independent or guided study through survey or other methods	1. Community Attitude Survey 2. "State of the Art" Studies
2. PATIENT CARE TEAM		Responsibility for provided comprehensive care jointly	Multidisciplinary	Clinical work with on or off campus with clinical conference a. Professional Orientation: Provided setting where proscribed disciplines learn to work together b. Patient Orientation: Provided setting where patient's needs proscribe the disciplines necessary for treatment	1. Role Definition 2. Interdisciplinary Communication 3. Integrated Patient Care 4. Non-Institutional Patient Care

* Adapted from a paper presented by Richard B. Fox, Medical Student, University of Minnesota, at the ASAHP Training Institute, August 19[illegible] Minneapolis, Minnesota.

III. INTERDISCIPLINARY EDUCATION IN HEALTH SCIENCES TEN BASIC ISSUES

Health Science education has traditionally placed emphasis on preparing its graduates to the highest degree of technical competence possible.

In this drive for technical competence as determined by the educational system there has been relatively minor emphasis placed on the "process", outside of technical competence, of the delivery of the skills which have been taught. This "process" of dealing with the system, other professionals, and different patient situations has become critical to the effective deployment of the full range of capabilities of today's health science student.

Reaction to this recent awareness of process has been an extremely active development of interdisciplinary programs for health science students. These efforts although applied in extremely varied situations and forms, generally can be reduced to four of the forgoing generic models:

I. Traditional
II. Common Interest
III. Case Presentation
IV. Health Team

These models all essentially possess a common objective of "preparing students to learn to work together(team)", but after that, their objectives and approaches to those objectives can be extremely divergent and create a different shape for each program. Educators faced with the task of designing a specific interdisciplinary program will find in their investigation of other efforts a number of common issues, which must be resolved in the earliest stages of development to provide the most effective interdisciplinary program.

In specific cases there are a multitude of issues, this paper will focus on the ten most common of these issues using the Health Care Team Model as a reference. Each of these issues has no right or wrong resolution, they are all situational, but the combinations of all is complex and left unresolved, can condemn the fledging interdisciplinary program to a purgatory from which there is no return. The purpose of this paper then is to raise those issues which need resolution before the interdisciplinary effort can succeed.

1. OBJECTIVES

At the heart of each interdisciplinary effort is the task of establishing well defined specific objectives for the program. The different perspectives and expectations engendered by the interdisciplinary concept mandate that all of those involved, students, faculty and administration, have the same understanding of the program objectives. Once these objectives are understood the development, implementation and evaluation processes are much easier to consider. The reinforcement of these objectives and their definition must be a continuous process to student and faculty. Because of the various types of health teams, objectives are critical to determining activity.

2. ADMINISTRATIVE RESPONSIBILITY

Interdisciplinary activities carry with them the connotation of democracy which for other purposes may be appropriate, but in the administration of an inter (multi) disciplinary effort should be pinpointed as soon as possible. The complexities of dealing across departmental, college, or even university lines can be necrotic to interdisciplinary efforts in which administrative responsibility is not clarified and accepted. Depending upon the objectives and the

scope of the program this responsibility should probably be vested in a structure outside of a traditional college department. Efforts based at the departmental level can succeed as long as the resources are adequate, but when the program begins to monopolize departmental resources, problems can develop.

Interdisciplinary efforts also require a certain faculty loyalty which is easier to maintain when everyone feels that they are supporting their own efforts and not those of another department competing for the same scarce resources.

3. PROGRAM CONTENT CONTROL

The old definition of a camel - "a horse that was designed by a committee," is very realistic parady which has to be faced in the design of an interdisciplinary effort. Control of the content of an interdisciplinary program can be a destructive or building force in programing. Resolution of this issue in most program efforts is found through the committee structure concept. However, the clear delineation of objectives and the pinpointing of administrative responsibility coupled with the sharing of program input with department chairmen and selected faculty generally provides the anticipated elements of democracy. Because interdisciplinary efforts are not "discipline" oriented, the content issue may sometimes evolve into a monarchy operation which is not necessarily evil.

4. FACULTY INPUT AND CONTROL

The facts of life are that in health science education the lack of faculty expertise in interdisciplinary efforts will create

a natural selection process leading to the interest of only a few faculty. These few faculty should have an open door to input relative to program content and design as they gain experience. Spreading out the control of course content in interdisciplinary efforts tends to diffuse the original purpose. Faculty also in spite of their interest need an intensive orientation to what ever the interdisciplinary effort might be. There is a natural general discomfort for some faculty who have to deal outside of their discipline with students from other areas.

5. DEPTH OF STRUCTURE AND CONTROL

Interdisciplinary efforts run the total spectrum of scale of control from intense structure ("today you all will work together and visit the following agencies, ask the following questions, and write a report on the following topic") to total lack of structure (we will drop you off in this community, come back for you in a week, meanwhile you all do a project together). While these examples may be oversimplified, they do typlify a basic problem - deciding how much direction to give students and how much freedom to allow. There is a companion problem relative to student direction which is faculty-student ratio. In some instances in health team models a corresponding faculty person has been assigned to each student on the team. In other instances one faculty per team has been successful and again student teams with no faculty assigned have been successful. The variations of program structure and faculty control must be determined based on a combination of program objectives, location and activities. It should be understood that the same pattern does not fit each interdisciplinary program.

6. LOCATION OF ACTIVITY

If one of the major purposes of interdisciplinary education is infact to acquaint students with the realistic "process" of the delivery of health care the choice of a location for the effort can be pivotal to the success of the program. It is much easier for health team programs to stay within the confines of the medical center than to move into a realistic community setting, however, a real question should be raised relative to the objectives of inter-disciplinary program if that is the choice.

7. TYPES OF STUDENTS

A major issue arises here which needs to be resolved: is the program to be for a professional orientation team or a patient orient d team. Professional Orientation teams (medical student, nursing student and social work student are the only ones eligible) are generally oriented to teaching "professional" togetherness which patient orientation teams (anybody who wants to participate can) are generally oriented to teaching the "process" of care as centered around the concept of meeting the patient's needs. The Professional Orientation team is perhaps the more comfortable for students and faculty since they have expectations of their roles which give them some support. Unfortunately this experience may tend to convince the student that this is the only team process. Patient Orientation teams can create great frustration on the part of students initially until they settle into a pattern which is comfortable. This may be the most beneficial approach, however, in preparing students to meet the unexpected combinations they will find in their future practices.

8. ACADEMIC LEVELS OF STUDENTS

One of the real difficulties in interdisciplinary education is finding the commondality of student knowledge that brings them to such a program on an equal basis. Many programs assume that academic levels of students is that commondality. However, the most logical thought is attempting to bring students together based on clinical experience. A combination of first year medical students and fourth year physical therapy students is unfair to the medical student because the clinical competency range is too great. Our experience has shown that second semester sophomore Associate Degree students and second semester senior Bacculaureate students can bring the same level of expertise to a program. This works with Patient Oriented teams but must be examined more carefully with the role of Professional Orientation teams. Personal maturity is another issue which enters into the academic level question. The assumption that graduate students are more mature than undergraduate students is generally accepted as true by many programs, but our experience has not proven this to be a universal truth.

9. PARTICIPATION REQUIREMENT

Generally interdisciplinary programs are voluntary for students. This issue is one that can make a difference in the conduct of the program. Under the voluntary concept students self select themselves. Thus, there is a tendency to heighten the level of maturity while bringing on board the student who sees the value of interdisciplinary activities. In dealing with the mandatory student some times the initial reaction of the student can provide a problem relative to attitude towards this new style of learning. Unfortunately, the student who does not see the purpose of interdisciplinary activities

is probably the one who needs the experience the most, but may be the most difficult to with which to deal. Regardless of the participation there should also be some provision for academic credit in such programs.

10. EVALUATION

Interdisciplinary activities need a constant evaluation to show up weaknesses that inevitably become apparent as the program progresses. This total concept of evaluation should come in two distinct areas: 1) Program Concept - subjective 2) Knowledge Gained - objective. The program concept is perhaps the easiest to evaluate as long as all those touched by the program are providing serious input into the evaluation process. In dealing with the knowledge gained aspects of the program interdisciplinary efforts find that they are dealing with both factual knowledge and an attitudinal knowledge. Measuring a student's knowledge of a concept of the health care system is a more simple task than determining whether or not they have acquired the proper perspective in dealing with other health team members in behalf of the patient. Various programs have utilized instruments which attempt to get at the measurable qualities of interdisciplinary education with no apparent concensus as to which is the best. Development of the interdisciplinary concept and the evaluation effort should be simultaneous. Provision for change through evaluation should be an integral concept of all interdisciplinary programs.

SUMMARY

Interdisciplinary efforts in health science education today run a great spectrum of activity and purpose. There are however, common issues which should be decided, one way or another, during the design of such programs. These issues - objectives, administrative responsibility, program content, control, faculty input and parti-

cipation, depth of structure and control, location of activity, types of students, student activities, academic level of students, participative requirement, and evaluation are almost totally intertwined and their early resolution can lead to the success or failure of the interdisciplinary effort.

IV. SELECTED BIBLIOGRAPHIES

Researching the literature is the acceptable first step in the planning of any academic program. The planner who goes first to the literature on interdisciplinary education in the health sciences is immediately overwhelmed by a plethora of books, journal articles, and other such resources with the buzz word "team" in their title. An additional problem faced by the researcher is the lack of topical division of the content of "team" literature. It is also true that many worthwhile interdisciplinary education programs have not found their way into the established literature.

Bearing these items in mind this selected bibliography is divided into two parts:

1. Interdisciplinary Team and Education Concepts - these references are based on the relevant issues of philosophy in interdisciplinary education and examples of practical, established health teams providing patient care.

2. Student Interdisciplinary Programs in Action - these references are based on student related activities in interdisciplinary education.

The reader will note immediately the brevity of this bibliography, but upon using it, will appreciate that brevity. This bibliography is intended to be brief, but in the estimation of the author contains some of the most relevant literature the inquirer into interdisciplinary health sciences efforts will need.

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7. An Organizational Development Approach to Improving the Effectiveness of Neighborhood Health Care Teams: A Pilot Program, Ronald E. Fray and Bernard A. Leach, Unpublished Master's Thesis, Alfred P. Sloan School of Management, Massachusetts Institute of Technology, Cambridge, Massachusetts.

8. Team Practice and the Specialist, An Introduction to Interdisciplinary Teamwork, John J. Horwitz, Ph. D., Charles C. Thomas, publisher, Springfield, Illinois, 1970.

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13. "Factors Influencing the Effectiveness of Health Teams", Irwin M. Rubin and Richard Beckhard, Milbank Memorial Fund Quarterly, Vol. L, No 3, Part 1, July 1972, pp. 317-335.

14. The Team Approach to Primary Health Care, Alberta W. Parker, M.D., University Extension, University of California, Berkeley, 1972.

15. "Interdisciplinary Health Science Education Models", (mimeographed), Richard B. Fox, Medical Student, University of Minnesota Health Sciences Center, Minneapolis, Minnesota, 55455.

16. "Integrated Teaching for Medicine and Allied Health", D. Cramer Reed, M.D., Journal of Allied Health, Fall 1973, pp. 159-162.

17. "Interdisciplinary Education in the Health Professions: A Caveat from Research," Robert E. Roush, Ed. D., Journal of Allied Health, Fall 1973, pp. 150-154.

18. "Yale Studies in Family Health Care, III the Health Care Team," Jerome S. Beloff, M.D., and Marion Willet, RN, JAMA, Vol. 205, No. 10, September 2, 1968, pp. 663-669.

19. "An Experience with Interprofessional Education," George Szasz, M.D., The Milbank Memorial Fund Quarterly, Vol. 47, October 1969, pp. 449-475.

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21. "The Primary Care Health Team", Harold Wise, M.D., Archives of Internal Medicine, Vol. 130, Sept. 1972, pp. 438-444.

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STUDENT INTERDISCIPLINARY PROGRAMS IN ACTION

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23. "Interdisciplinary Education in the Rural Home Health Agency," Tom Connelly, Jr., Ruth Assell, and Patsy Peck, Public Health Reports, Vol. 90, No. 4 , July - August 1975, pp. 325-330.

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V. EXISTING PROGRAM REFERENCES

Catalogue shopping has become a most convenient form of shopping in America today. This section is offered in that same context. The programs enumerated have been catalogued according to certain characteristics.

In addition their generic model classification, selected bibliography references have been furnished. (i.e., IV,2a-3 is "Health Team Model, Professional Orientation" (2a), "Teaching Strategies for Interdisciplinary Education," T.A.Rosenaur and Dorthy T. Fuller, Nursing Outlook, Vol. 21, No. 3, March 1973, pp. 159-162 (3)).

These references have been obtained from the literature, the grape vine and chance contacts.As a result of this non-scientific inquiry, there are a number of programs which exist from whom information has not been obtained. These references are offered as typical of existing programing as the reader will discover when he puts this document aside and begins his original quest for interdisciplinary references.

Program Location and Contact Person	Activity	Objectives	Faculty	Student Participation	Location of Activity	Date Begun
George Szasz, M.D. Division of Interprofessional Education University of British Columbia Health Sciences Center Vancouver, Canada (II)	Academic/Administrative Division Assisting on a university wide basis	1. Develop, assist, and stimulate inter professional education affairs 2. Technical support for interdisciplinary student activities 3. Research in evaluation 4. Liaison activities with various health care agencies	Drawn from all disciplines	all levels and disciplines --- Medicine, Nursing, Dentistry, Dental Hygiene Pharmacy, Occupational Therapy, Physical Therapy Social Work, Nutrition, Clinical Psychology	On and off campus	1968
Tom Klopfenstein, Ph. D. Associate Dean Health Technology Kellogg Community College 450 North Avenue Battle Creek, Michigan (II)	Core Semester for 8 health technology programs --- Common coursework and integrated coursework for these students	1. Health team concept 2. Understanding the role of allied health personnel in delivery of care 3. Reduce attrition by acquainting students with all programs (mobility) 4. Educational Economy	Drawn from all disciplines	Dental Hygiene, Dental Assistant, Registered Nurse, Licensed Practical Nurse, Medical Laboratory Technician, Physical Therapy Assistant, Radiologic Technologist	On campus	1971

Program Location and Contact Person	Activity	Objectives	Faculty	Student Participation	Location of Activity	Date Begun
Robert A. Hoekelman, M.D. Department of Pediatrics University of Rochester School of Medicine and Dentistry Rochester, New York (II)	Classroom teaching on historical, educational, organizational and operational aspects of medicine, nursing, and the health care system --- group discussions and projects	1. Increase student participation of own discipline and others 2. Experience in interprofessional relationships 3. Provide a broader view of patient care needs	Medical - Nursing Set up as discussion leaders	Medical - freshmen Nursing - senior --- Voluntary	Campus, classroom	1970
Pearl P. Rosenberg, Ph. D. Associate Professor Physical Medicine and Rehabilitation Department 860 Mayo, Box 297 University of Minnesota Minneapolis, Minnesota 55455 (II)	Three academic quarters of classwork, lecture, student projects --- a) group dynamics b) problem solving c) health problems --- students formed into four teams for reports and group activities	1. Disciplines gain knowledge of each other 2. Increase student ability to deal with interdisciplinary groups 3. Knowledge of health care delivery systems	Drawn from total medical center based on program topics	Optional --- Medicine, Dentistry, Dental Assistant, Dental Hygiene, Dietetics, Health Education, Hospital Administration, Medical Technology, Nursing, PT, OT, Nutrition, Pharmacy, X-ray, Psychiatry, Social Work, Veterinary Medicine	Campus, classroom	1972

Program Location and Contact Person	Activity	Objectives	Faculty	Student Participation	Location of Activity	Date Begun
Molly T. Vogt, Ph. D. Chairman Department of Health Related Professions Interdisciplinary Programs School of Health Related Professions University of Pittsburgh (II)	Administrative and teaching unit within school of HRP --- 1. Provide Care Courses 2. Research in improved methods of instruction 3. Multi-disciplined continuing education 4. 2 + 2 program 5. Interdisciplinary graduate program	1. Enhancement of interdisciplinary experience by providing common learning experiences	Teaching/faculty ratio depending on courses offered	courses part of mandatory and optional curriculum --- majors and non-majors --- credit by course designation	University Classroom setting	1973 (Originally in 1971)
Jan Howard, Ph. D. University of California Division of Ambulatory and Community Medicine School of Medicine (II-6)	Interdisciplinary course in "Social Aspects of Health and Disease", classroom program with optional discussion --- One semester 10 - 2 hour lectures with discussion	1. Interdisciplinary contact 2. More exposure to social facets of health care	Medicine, Nursing, Dentistry, Pharmacy, Dental Hygiene	Voluntary --- Academic credit - 3 hrs. --- Medicine, Dentistry, Pharmacy, Nursing, Dental Hygiene, Physical Therapy ALL LEVELS	Classroom	1968

Program Location and Contact Person	Activity	Objectives	Faculty	Student Participation	Location of Activity	Date Begun
John Parasandola, Ph. D. University of Wisconsin Madison, Health Science Ctr. School of Pharmacy (II-7)	Academic Courses "Health Care Systems, An Interdisciplinary Approach" --- one lecture, one discussion period per week --- materials and readings	1. Present common body of knowledge about health care systems 2. Career decision 3. Stimulation of interaction of students/faculty 4. Provide basis for clinical setting interdisciplinary education	Interdisciplinary (guest speaker)	Voluntary --- Credit --- Freshmen through seniors majors and non-majors in health science --- 14 students per discussion group	University, classroom	1970
DeWitt C. Baldwin, M.D. Co-Director Health Sciences Program University of Nevada, Reno Reno, Nevada (II and IVb)	Administrative organization responsible for providing core behavioral and physical science courses as well as community health experience and advisement for pre professional students	1. Team 2. Career advisement 3. Core curriculum	Departmental and Interdisciplinary	Pre Professional Dental, Pharmacy, Medicine, Physical Therapy, Medical Technology, Nursing, Health Education, Speech Pathology	Campus, classroom and Community	1971
Dorthy Verstraete University of Minnesota Office of the Coordinator of Allied Health Programs Health Sciences Center Minneapolis, Minnesota (III)	Presentation of case studies illustrating delivery of care to persons or families with emphasis upon the more commonly encountered clinical problems --- lecture and independent student research	1. Demonstrate roles of health related professionals in the maintenance of health 2. Exploration of interdisciplinary approaches to clinical management/ prevention of disease 3. Identify areas of role overlap, independence, and interdependencies	Dietetics Physical Therapy Occupational Therapy, Medical Technology, Dental Hygiene	Voluntary --- Open to upper division and graduate students in health professions	Campus, classroom	1973

INTERDISCIPLINARY ACTIVITIES IN HEALTH SCIENCE EDUCATION

Program Location and Contact Person	Activity	Objectives	Faculty	Student Participation	Location of Activity	Date Begun
Mitchell Schorow, Ph. D. Director Medical Sciences Education University of Utah Medical Center Salt Lake City, Utah 84101 (III)	Course-Introduction to the Medical Care System- topical course utilizing case studies; use of actors and staged presentations, group discussions, lecture skits	1. Team 2. Recognition of patient as primary focus	Interdisciplinary	Elective course for credit Medicine, Nursing, Social Work, Pharmacy and others	Classroom	1972
William H. Chew, Jr. M.D. Medical College of Georgia School of Medicine Augusta, Georgia (IV, 2a)	Classroom and clinical practice in a joint interdisciplinary setting; complete 2 year curriculum, students spend 2 semesters in "Team" course and 2 semesters in discipline	1. Develop team concept among selected disciplines 2. Problem solving skills 3. Technology utilization	Medical School and Nursing	First year students in Medicine, Nursing, Physician Assistant	Medical Center	1973
William Dow, M.D. Student Health Coalition Center for Health Services Vanderbilt Medical Center Nashville, Tennessee (IV,2b-18)	Summer projects, built around "Health Fairs", which offer screening and referral services; other projects also	1. Develop team approach 2. Provide service to those who need it	Volunteer Physician Supervisors	Medicine, Nursing Social Work, Law, Speech/Hearing, Dental, Clinical Psychology	Community	1968

INTERDISCIPLINARY ACTIVITIES IN HEALTH SCIENCE EDUCATION

Program Location and Contact Person	Activity	Objectives	Faculty	Student Participation	Location of Activity	Date Begun
Bill Carlton, Ed. D. Appalachian Regional Hospitals, Incorporated Office of Education Middlesboro, Kentucky (IV,2b-4)	Family centered practice, home health visits --- 10 weeks in summer	1. Teamwork 2. Family Health 3. Manpower Recruitment	Home Health Supervisors	Voluntary --- non-credit or credit depending on school --- Nursing, Medicine, Dentistry, Pharmacy, Clinical Nutrition, Health Education, Social Work ALL LEVELS	Home Health Agencies	1972
Tom Connelly, Jr., Director Office of Special Programs College of Allied Health Professions University of Kentucky Lexington, Kentucky 40506 (IV,1 and 2b-5)	Observation of Community Agencies on a rotating basis Clinical Practice in conjunction with home health agency --- Three weeks, plus on-campus orientation during semester	1. Teamwork 2. Community Orientation 3. Introduction to Health Care Environment 4. Expanded experiences in health areas --- Three weeks, plus on-campus orientation during semester	Community Health Dental Hygiene, Respiratory Therapy, Medical Technology, Physical Therapy, Speech & Hearing, Pastoral Counseling, Nursing --- one faculty per team	Mandatory for B.S. students Voluntary for A.A., M.S. and Ed. D. Students --- 1. Teams made up of six students plus one faculty member 2. Voluntary for all --- academic credit - 3 hrs. --- Pharmacy, Dentistry, Nursing, Respiratory Therapy, X-ray, A.A., Community Health, Physical Therapy, Dental Hygiene, Medical Technology, B.S., Speech & Hearing - B.S. - M.S. Clinical Pastoral Counseling, Social Work, M.S. Allied Health Education - M. Ed. - Ed.D.	Community agencies hospitals, nursing home, health department, clinics, mental health centers home health agencies all off-campus and out-of-town	1972

Program Location and Contact Person	Activity	Objectives	Faculty	Student Participation	Location of Activity	Date Begun
S. W. Barnette, M.D. Department of Pediatrics Preventive Medicine Division of Health Administration of University of Colorado Medical Ctr. Denver, Colorado (IV,2b-8)	Training session orientating them to areas/agencies --- health education, patient transportation, minor treatment, home visit --- Summer program (10 weeks)	1. Provide health care to poor 2. Team 3. Rural Recruitment 4. Expansion of knowledge of rural health problems	Field Preceptors	Voluntary --- Medicine, Dentistry, Pharmacy, Dental Hygiene, Nursing, Child Health Associates (30 total) --- no credit	Community of service - hospitals, physicians offices, headstart all day care center	1970
Elizabeth Yerxa, Ph. D. Rancho Los Amigos Hospital Allied Health Interdisciplinary Project Downey, California Sponsored by: University of Southern California School of Medicine Department of Community Medicine (IV,2b)	Patient conferences Ward rounds --- weekly seminars on teams --- patient care --- 8 weeks summer program	1. Team 2. Improve Clinical skills 3. Understand which institutional policies are most conducive to patient centered care	Professions are matched to a preceptor on a one to one basis	Voluntary --- Nursing, Medicine, Social Work, Occupational Therapy, Physical Therapy, Public Administration (al total) --- non-credit	Rehabilitation Hospital Center	1973
John Parasandola, Ph. D. University of Wisconsin Madison Health Science Ctr. School of Pharmacy (IV, 2b-7)	Orientation to center and mental retardation --- Staff conference case presentation conducted by students on alternate weeks --- patient interviews and patient care plan --- group dynamics education	1. Determine feasibility of student health team 2. Identify knowledge and skills prerequisite to clinical learning experiences --- 1. Identify environmental and personal living patterns that influence health 2. Team 3. Identify internal and external factors affecting health agencies	Center staff	Voluntary --- Non-credit --- 2 to 4 1/2 years post high school	University Medical Retardation, Diagnostic and treatment unit	1971(only done once)

INTERDISCIPLINARY ACTIVITIES

IN HEALTH SCIENCE EDUCATION

Program Location and Contact Person	Activity	Objectives	Faculty	Student Participation	Location of Activity	Date Begun
Lois Gonzales University of New Mexico Health Science Center North Campus Albuquerque, New Mexico 87131 (IV,2a-2b)	Students participate in: 1. clinical care of patients 2. health education programs 3. special projects 4. home care 5. community development	1. Team 2. Learn community health delivery 3. Clinical experience 4. Provide health care to underserved areas	six of local practitioners of of student disciplines and faculty from university of a visiting basis	2 Medicine - 4th year 2 Nursing - 4th year 1 Pharmacy - 5th year --- 8 weeks to three months student choice --- voluntary - academic credit given --- each team has five members on a year round basis	two rural ccommunity clinics	1973
Mrs. Ethel J. Soulary University of Miami School of Medicine Dept. of Family Practice Miami, Florida (IV, 2a-1)	Family assessment home visits, clinic exams, classroom seminars monthly --- Family centered --- one semester	1. Teamwork 2. Learn background of other students 3. Comprehensive Care 4. Demonstrate Delivery of Care	Medicine, Nursing Social Work --- Supervised activities on a one to one basis	Voluntary --- 5 teams, three students each --- non-credit --- Nursing - sophomore Medicine - Freshmen Social Work - 1st year	University, model family practice unit	1970
Janet A. Rosenaur University of California San Francisco Medical Ctr. Ambulatory Care Division (IV,2a-3)	Primary Family Care --- Interviewing, care planning, home visits, treatment --- one semester	1. Role Definition 2. Teamwork 3. Primary Care	Medicine, Nursing --- Supervised Activities directly	Voluntary - optional as part of community health rotation in nursing --- 2 students to a team --- academic credit --- nursing - senior medicine - senior	University, primary care clinic	1967

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Sr. Martha Discher Kentuckiana Metroversity CHOPS 1817 South 34th Street Louisville, Kentucky (IV,1)	Classroom, Community, Observation --- one semester --- 14 hours per week	1. Community Health Education 2. Teamwork Orientation	visiting Lecturers	Voluntary --- academic credit --- Nursing, Medicine, Dentistry, Social Work, Dietetics ALL LEVELS	Neighborhood health center and community agencies	1972
John A. LeCasse , Director Multidisciplinary Preceptorship Project Medical Care Development,Inc 295 Water Street Augusta, Maine (IV,2b-15)	Interdisciplinary teams of between 3 and 5 students will be placed for periods of 4 to 8 weeks in local communities --- practice communities will be basically in rural underserved areas --- some patient care is to be rendered by students	1. To show interrelationship of various community resources for patient care 2. Demonstrate team concept of patient care 3. Attract students to practice in rural underserved areas	Local preceptors-physicians used as "Lead" preceptor and other health professions as assitional preceptors	Voluntary, from various colleges in New England To be considered as an elective in academic program --- Medical students, Nursing, Allied Health	Community Settings	1974
John Cady, Instructor School of Management Suny, Buffalo Buffalo, New York (IV,2b-14)	Rural Preceptorship --- Patient care and observation of practioners at work	1. Teamwork 2. Attract students to rural areas by increasing their knowledge of rural practice	Local preceptors matched to student disciplines	Medicine, Nursing, Pharmacy, Physical Therapy, Pediatry, Hospital Administration, Medical Social Work, Dentistry, Medical Technology	Rural, Community for 8 weeks during summer --- no academic credit	1973
Gail MacDougall,Lecturer Department of Preventive Medicine Dalhousie University Faculty of Medicine Halifax,Nova Soctia Canada (IV,2b-24)	Students in teams are assigned one family to work with for the academic year, faculty specialist available as well as community specialist	1. Team work orientation	Faculty work in advisory capacity to each team	Mandatory for 3rd year medical students, voluntary Allied Health --- Medicine, Nursing, Social Professions, Dietetics, Dental Hygiene	Community September-May	1964